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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

JOHN R. ASHCROFT

SECRETARY OF STATE

MISSOURI REGISTER

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Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at sos.mo.gov/adrules/pubsched.

HOW TO CITE RULES AND RSMO

RULES

The rules are codified in the *Code of State Regulations* in this system–

Title		Division	Chapter	Rule
3	CSR	10-	4	.115
Department	*Code of State Regulations*	Agency Division	General area regulated	Specific area regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation, for example, 3 CSR 10-4.115 NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

Code and *Register* on the Internet

The *Code of State Regulations* and *Missouri Register* are available on the Internet.

The *Code* address is sos.mo.gov/adrules/csr/csr

The *Register* address is sos.mo.gov/adrules/moreg/moreg

These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) business days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 41—General Tax Provisions

EMERGENCY AMENDMENT

12 CSR 10-41.010 Annual Adjusted Rate of Interest. The department proposes to amend the purpose, emergency statement, section (1), and authority.

PURPOSE: This emergency amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2020.

*EMERGENCY STATEMENT: The director of revenue is mandated to establish not later than October 22 annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percent. This emergency amendment is necessary to ensure public awareness and to preserve a compelling governmental interest requiring an early effective date in that the amendment informs the public of the established rate of interest to be paid on unpaid amounts of taxes for the 2020 calendar year. A proposed amendment, that covers the same material, is published in this issue of the **Missouri Register**. The director has limited the scope of the emergency amendment to the circumstances creating the emergency. The director has followed procedures calculated to assure fairness to all interested persons and parties and has complied with protections extended by the **Missouri** and **United States Constitutions**. Emergency amendment filed October 21, 2019, becomes effective January 1, 2020, expires June 28, 2020.*

(1) Pursuant to section 32.065, RSMo, the director of revenue upon official notice of the average predominant prime rate quoted by commercial banks to large businesses, as determined and reported by the Board of Governors of the Federal Reserve System in the Federal Reserve Statistical Release H.15(519) for the month of September of each year has set by administrative order the annual adjusted rate of interest to be paid on unpaid amounts of taxes during the succeeding calendar year as follows:

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%
2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%
2013	3%
2014	3%
2015	3%
2016	3%
2017	4%
2018	4%
2019	5%
2020	**5%**

*AUTHORITY: section 32.065, RSMo [2000] **2016**. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 21, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Counties	*This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate. The 2020 interest rate imposed on delinquent taxes will be the same as the rate imposed in 2019.*
Cities	
Special Taxing Districts	

III. WORKSHEET

The proposed amendment establishes the rate of interest for 2020 at five percent (5%), remaining the same as the rate in 2019.

The future amount of past due taxes is unknown. With the 2020 interest rate imposed upon delinquent taxes remaining the same as that imposed in 2019, public entities realize no additional fiscal impact. This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

Interest on Delinquent Taxes Paid to Department of Revenue

	Current Rule 5.00%	**Proposed Amendment 5.00%**
Past due tax amount	$100.00	$100.00
Interest Amount (%)	x 5.00	x 5.00
Total Amount Due	**$105.00**	**$105.00**

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the Director of Revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year, as set by the Board of Governors of the Federal Reserve, rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2019 was 5.25 percent.

FISCAL NOTE
PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule:	**Classification by types of the business entities which would likely be affected:**	**Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:**
Any taxpayer with delinquent tax.	Any taxpayer with delinquent tax.	*This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate. The 2020 interest rate imposed on delinquent taxes remains the same as that imposed in 2019. The actual number of affected taxpayers is unknown.*

III. WORKSHEET

The proposed amendment establishes the rate of interest for 2020 at five percent (5%), the same as the rate in 2019.

This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate. Because the 2020 interest rate imposed on delinquent taxes remains at the same rate as that imposed in 2019, the interest rate remains the same on each $100 of delinquent taxes to private entities. The actual number of affected taxpayers is unknown.

Interest on Delinquent Taxes Paid to Department of Revenue

	Current Rule 5.00%	**Proposed Amendment 5.00%**
Past due tax amount	$100.00	$100.00
Interest Amount (%)	x 5.00	x 5.00
Total Amount Due	**$105.00**	**$105.00**

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the Director of Revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year, as set by the Board of

Governors of the Federal Reserve, rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2019 was 5.25 percent.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program

EMERGENCY AMENDMENT

13 CSR 70-10.030 Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/IID Services. The division is amending sections (2), (3), (4), (7), (8), and (10), deleting section (6), and renumbering the remaining sections.

PURPOSE: The MO HealthNet Divisions seeks through this amendment to rebase the per diem rates paid to nonstate-operated intermediate care facilities for individuals with intellectual disabilities (ICF/IID) for services, to clarify the process for determining reimbursement rates, to remove and/or replace obsolete processes and language, and to combine and remove duplicative language.

*EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division, by rule and regulation, must define the reasonable costs, manner, extent, quantity, quality, charges, and fees of medical assistance provided to MO HealthNet participants. Effective for dates of service beginning January 1, 2019, the MO HealthNet Division will rebase the per diem rates of nonstate-operated ICF/IID facilities using a more current year cost report base. The appropriation by the General Assembly for State Fiscal Year (SFY) 2019 and SFY 2020 included additional funds to increase nonstate-operated ICF/IID reimbursement rates which will be used to fund the rebased per diem rates. The increased reimbursement resulting from the rebased rates is necessary to ensure that payments for ICF/IID per diem rates are in line with the funds appropriated for that purpose. There are a total of seven (7) nonstate-operated ICF/IID providers currently enrolled in Missouri Medicaid, all of which will receive a rebased per diem rate. This emergency amendment will ensure payment for ICF/IID services to approximately seventy-nine (79) ICF/IID Missourians in accordance with the appropriation authority. For the rebased per diem rates to be implemented, the MO HealthNet Division was required to submit a Medicaid State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS). CMS approved the SPA on June 24, 2019. The proposed state regulation will be effective on or around April 30, 2020. This emergency amendment must be implemented on a timely basis to ensure that quality ICF/IID services continue to be provided to Medicaid patients in ICF/IID facilities in accordance with the appropriation authority. As a result, the MO HealthNet Division finds an immediate danger to public health, safety and/or welfare and a compelling governmental interest, which requires emergency action. The Missouri Medical Assistance program has a compelling government interest in providing continued cash flow for ICF/IID services and to adequately compensate these providers for costs expended on the state Medicaid population that they serve. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The MO HealthNet Division believes that this emergency amendment is fair to all interested persons and parties under the circumstances. A proposed amendment covering this same material will be published in the **Missouri Register**. This emergency amendment was filed October 25, 2019, becomes effective November 8, 2019, and expires May 5, 2020.*

(2) General Principles.

(A) The MO HealthNet program shall reimburse qualified providers of ICF/IID *s*ervices based solely on the individual MO HealthNet participant's days of care (within benefit limitations) multiplied by the facility's Title XIX per diem rate less any payments made by participants.

(B) Effective November 1, 1986, the Title XIX per diem rate for all ICF/IID facilities participating on or after October 31, 1986, shall be the lower of—

[1. The average private pay charge;

2. The Medicare per diem rate, if applicable;

3. The rate paid to a facility on October 31, 1986, as adjusted by updating its base year to its 1985 fiscal year. Facilities which do not have a full twelve- (12-) month 1985 fiscal year shall not have their base years updated to their 1985 fiscal years. Changes in ownership, management, control, operation, leasehold interests by whatever form for any facility previously certified for participation in the MO HealthNet program at any time that results in increased capital costs for the successor owner, management, or leaseholder shall not be recognized for purposes of reimbursement; and

4. However, any provider who does not have a rate on October 31, 1986, and whose facility meets the definition in subsection (3)(J) of this rule, will be exempt from paragraph (2)(B)3., and the rate shall be determined in accordance with applicable provisions of this rule.]

1. The Medicare per diem rate, if applicable; or

2. The reimbursement rate as determined in accordance with this regulation.

(C) This plan has an effective date of November 1, 1986, at which time prospective per diem rates shall be calculated for the remainder of the state's FY-87 and future fiscal years. Per diem rates established by updating facilities' base years to FY-85 may be subject to retroactive and prospective adjustment based on audit of the facilities' new base year period.

(D) The Title XIX per diem rates as determined by this plan shall apply only to services furnished on or after November 1, 1986.

(E) All illustrations and examples provided throughout this rule are for illustration purposes only and are not meant to be actual calculations.

(3) Definitions.

(A) **"**Allowable cost areas*[.]***" means** *[T]***t**hose cost areas *[which]***that** are allowable for allocation to the MO HealthNet program based upon the principles established in this rule. The allowability of cost areas, not specifically addressed in this rule, will be based upon criteria of the *Medicare Provider Reimbursement Manual* (HIM-15) and section *[(7)]***(6)** of this rule.

(B) **"**Average private pay charge*[.]***" means** *[T]***t**he *[average private pay charge is the]* usual and customary charge for non-MO HealthNet patients determined by dividing total non-MO HealthNet days of care into total revenue collected for the same service that is included in the MO HealthNet per diem rate, excluding negotiated payment methodologies with the Veterans Administration and the Missouri Department of Mental Health.

[(C) Committee. The advisory committee defined in subsection (6)(A) of this rule.]

*[(D)]***(C) "**Cost report*[.]***" *[The cost report shall]* means a report** *[detail]* **detailing** the cost of rendering covered services for the fiscal reporting period. Providers must file the cost report on forms provided by and in accordance with the procedures of the *[department]* **Department of Social Services**.

*[(E)]***(D) "**Department*[. The department, unless otherwise specified, refers to]***" means** the Missouri Department of Social Services**, unless otherwise specified**.

*[(F)]***(E) "**Director*[. The director, unless otherwise specified, refer to]***" means** the director **of the** Missouri Department of Social Services**, unless otherwise specified**.

*[(G)]***(F) "**Effective *[date.]* **Date" means** *[1. The plan effective date shall be]* November 1, 1986.

[2. The effective date for rate adjustments granted in accordance with section (6) of this rule shall be for dates of service beginning the first day of the month following the director's, or his/her designee's, final determination on the rate.]

*[(H)]***(G) "**ICF/IID*[. Nonstate-operated]*" **means nonstate-operated** facilities certified to provide intermediate care for individuals with intellectual disabilities under the Title XIX program.

*[(I)]***(H) "**Medicare *[rate. This is]* **Rate" means** the allowable cost of care permitted by Medicare standards and principles of reimbursement.

*[(J)]***(I) "**New *[construction. Newly]* **Construction" means newly** built facilities or parts, for which an approved Certificate of Need (CON) or applicable waivers were obtained and which were newly completed and operational on or after November 1, 1986.

*[(K)]***(J) "**New *[owners. Original]* **Owners" means the original** owners of new construction.

*[(L)]***(K) "**Providers*[. A provider]*" **means,** under the Prospective Reimbursement Plan *[is]***,** a nonstate-operated ICF/IID facility with a valid participation agreement**,** in effect on or after October 31, 1986, with the Missouri Department of Social Services for the purpose of providing long-term care (LTC) services to Title XIX-eligible participants. Facilities certified to provide intermediate care services to individuals with intellectual disabilities under the Title XIX program may be offered a MO HealthNet participation agreement on or after January 1, 1990, only if 1) the facility has no more than fifteen (15) beds for individuals with intellectual disabilities, and 2) there is no other licensed residential living facility for individuals with intellectual disabilities within a radius of one-half (1/2) mile of the facility seeking participation in the MO HealthNet program.

*[(M)]***(L) "**Reasonable and *[adequate reimbursement. Reimbursement]* **Adequate Reimbursement" means reimbursement** levels which meet the needs of an efficiently and economically operated facility and which in no case exceed normal market costs.

*[(N)]***(M) "**Related parties*[. Parties are related when—]*" **means—**

1. An individual or group, regardless of the business structure of either, where, through their activities, one (1) individual's or group's transactions are for the benefit of the other and the benefits exceed those which are usual and customary in the dealings;

2. One (1) or more persons *[has]* **have** an ownership or controlling interest in a party, and the person(s) or one (1) or more relatives of the person(s) has an ownership or controlling interest in the other party. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity, directly or through a subsidiary, operates a facility; or

3. As used in section (3), the following terms mean:

A. **"**Indirect *[ownership/interest]* **Ownership" or "Indirect Interest"** means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. **"**Ownership *[interest]* **Interest"** means the possession of equity in the capital, in the stock, or in the profits of an entity;

C. **"**Ownership *[or controlling interest is when]* **Interest" or "Controlling Interest" means** a person or corporation(s)—

(I) Has an ownership interest *[totalling]* **totaling** five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by an entity, if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from the obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership;

D. **"**Relative**"** means persons related by blood or marriage to the fourth degree of consanguinity; and

E. **"**Entity**"** means any person, corporation, partnership, or association.

*[(O)]***(N) "**Rural*[. Those]*" **means those** counties *[which]* **that** are not defined as urban.

*[(P)]***(O) "**Urban*[. The urban counties are]*" **means counties that are** standard metropolitan statistical areas including Andrew, Boone, Buchanan, Cass, Christian, Clay, Franklin, Greene, Jackson, Jasper, Jefferson, Newton, Platte, Ray, St. Charles, St. Louis, and St. Louis City.

(4) *[Prospective Reimbursement]* **ICF/IID** Rate Computation. **Except in accordance with other provisions of this rule, the provisions of this section shall apply to all providers of ICF/IID services certified to participate in Missouri's MO HealthNet program. Rate determination shall be based on reasonable and adequate reimbursement levels for allowable cost items described in this rule which are related to ordinary and necessary care for the level-of-care provided for an efficiently and economically operated facility. All providers shall submit documentation of expenses for allowable cost areas. The department shall have authority to require those uniform accounting and reporting procedures and forms as it deems necessary. A reasonable and adequate reimbursement in each allowable cost area will be determined.**

(A) *[Except in accordance with other provisions of this rule, the provisions of this section shall apply to all providers of ICF/IID services certified to participate in Missouri's MO HealthNet program.]* **Prospective Reimbursement Rate Determination through December 31, 2018**.

1. *[ICF/IID facilities*

A. Except in accordance with other provisions of this rule, the MO HealthNet program shall reimburse providers of these LTC services based on the individual MO HealthNet-participant days of care multiplied by the Title XIX prospective per diem rate less any payments collected from participants.] The Title XIX prospective per diem reimbursement rate for the remainder of state Fiscal Year 1987 shall be the facility's per diem reimbursement payment rate in effect on October 31, 1986, as adjusted by updating the facility's allowable base year to its 1985 fiscal year. Each facility's per diem costs as reported on its Fiscal Year 1985 Title XIX cost report will be determined in accordance with the principles set forth in this rule. If a facility has not filed a 1985 fiscal year cost report, **the MO HealthNet Division will use** the most current cost report on file with the department *[will be used]* to set *[its]* **a facility's** per diem rate. Facilities with less than a full twelve-(12-) month 1985 fiscal year will not have their base year rates updated.

*[B.]***2.** For state FY-88 and dates of service beginning July 1, 1987, the negotiated trend factor shall be equal to two percent (2%) to be applied in the following manner: Two percent (2%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1987, shall be added to each facility's rate.

*[C.]***3.** For state FY-89 and dates of service beginning January 1, 1989, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1988, shall be added to each facility's rate.

*[D.]***4.** For state FY-91 and dates of service beginning July 1, 1990, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1990, shall be added to each facility's rate.

5. Prospective payment adjustment (PPA). A FY92 PPA will be provided prior to the end of the state fiscal year for nonstate-operated ICF/IID facilities with a current provider agreement on file with the MO HealthNet Division as of October 1, 1991.

A. For providers that qualify, the PPA shall be the lesser of—

(I) The provider's facility peer group factor (FPGF) times the projected patient days (PPD) covered by the adjustment year times the prospective payment adjustment factor (PPAF) times the nonstate-operated intermediate care facility for individuals with intellectual disabilities ceiling (ICFIIDC) on October 1, 1991 (FPGF × PPD × PPAF × ICFIIDC). For example: A provider having nine hundred twenty (920) paid days for the period May 1991 to July 1991 out of a total paid days for this same period of twenty-eight thousand five hundred sixty-one (28,561) represents an FPGF of three and twenty-two hundredths percent (3.22%). So using the FPGF of 3.22% × 114,244 × 24.5% × $156.01 = $140,607; or

(II) The provider FPGF times one hundred forty-five percent (145%) of the amount credited to the intermediate care revenue collection center (ICRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

B. FPGF—is determined by using each ICF/IID facility's paid days for the service dates in May 1991 through July 1991 as of September 20, 1991, divided by the sum of the paid days for the same service dates for all providers qualifying as of the determination date of October 16, 1991.

C. ICFIIDC—is one hundred fifty-six dollars and one cent ($156.01) on October 1, 1991.

D. PPAF—is equal to twenty-four and one half percent (24.5%) for fiscal year 1992 which includes an adjustment for economic trends.

E. PPD—is the projection of one hundred fourteen thousand two hundred forty-four (114,244) patient days made on October 1, 1991, for the adjustment year.

6. FY-92 trend factor and Workers' Compensation. All facilities with either an interim rate or a prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of eight dollars and eighty-six cents ($8.86) per patient day related to the continuation of the FY-92 trend factor and the Workers' Compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/IID facilities.

7. FY-93 negotiated trend factor. All facilities with either an interim rate or prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of one dollar and sixty-six cents ($1.66) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/IID facilities.

*[E.]***8.** FY-96 negotiated trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning January 1, 1996, of six dollars and seven cents ($6.07) per patient day for the negotiated trend factor. This adjustment is equal to four and six-tenths percent (4.6%) of the weighted average per diem rates paid to nonstate-operated ICF/IID facilities on June 1, 1995, of one hundred and thirty-one dollars and ninety-three cents ($131.93).

*[F.]***9.** State FY-99 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1998, of four dollars and forty-seven cents ($4.47) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 1998, of one hundred forty-eight dollars and ninety-nine cents ($148.99).

*[G.]***10.** State FY-2000 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1999, of four dollars and sixty-three cents ($4.63) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on April 30, 1999, of one hundred fifty-four dollars and forty-three cents ($154.43). This increase shall only be used for increases for the salaries and fringe benefits for direct care staff and their immediate supervisors.

*[H.]***11.** State FY-2001 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 2000, of four dollars and eighty-one cents ($4.81) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on April 30, 2000, of one hundred sixty dollars and twenty-three cents ($160.23). This increase shall only be used for increases for salaries and fringe benefits for direct care staff and their immediate supervisors.

*[I.]***12.** State FY-2007 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase of seven percent (7%) to their per diem rates effective for dates of service billed for state fiscal year 2007 and thereafter. This adjustment is equal to seven percent (7%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2006.

*[J.]***13.** State FY-2008 trend factor. Effective for dates of service beginning July 1, 2007, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of two percent (2%) for the trend factor. This adjustment is equal to two percent (2%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2007.

*[K.]***14.** State FY-2009 trend factor. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2008.

*[L.]***15.** State FY-2009 catch up increase. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of thirteen and ninety-five hundredths percent (13.95%). This adjustment is equal to thirteen and ninety-five hundredths percent (13.95%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2008. This increase is intended to provide compensation to providers for the years where no trend factor was given. The catch up increase was based on the CMS PPS Skilled Nursing Facility Input Price Index (four- (4-) quarter moving average).

*[M.]***16.** State FY-2012 trend factor. Effective for dates of service beginning October 1, 2011, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of one and four tenths percent (1.4%) for the trend factor. This adjustment is equal to one and four tenths percent (1.4%) of the per diem rate paid to nonstate-operated ICF/IID facilities on September 30, 2011.

*[N.]***17.** State FY-2014 trend factor. Effective for dates of service beginning January 1, 2014, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF/IID facilities on December 31, 2013.

*[O.]***18.** State FY-2016 trend factor. Effective for dates of service beginning February 1, 2016, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of one percent (1%) for the trend factor. This adjustment is equal to one percent (1%) of the per diem rate paid to nonstate-operated ICF/IID facilities on January 31, 2016.

*[P.]***19.** State FY-2017 trend factor. Effective for dates of service

beginning September 1, 2016, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of two percent (2%) for the trend factor. This adjustment is equal to two percent (2%) of the per diem rate paid to nonstate-operated ICF/IID facilities on August 31, 2016.

*[Q.]***20.** State FY-2018 per diem adjustment. Effective for dates of service beginning September 1, 2017, all nonstate-operated ICF/IID facilities shall be subject to a decrease to their per diem rates of two and eighty-two hundredths percent (2.82%). This adjustment is equal to two and eighty-two hundredths percent (2.82%) of the per diem rate paid to nonstate-operated ICF/IID facilities on August 31, 2017.

(B) Per Diem Rate Calculation Effective for Dates of Service Beginning January 1, 2019. Effective for dates of service beginning January 1, 2019, the MO HealthNet Division shall rebase nonstate-operated ICF/IID facilities' per diem rates using the facilities' 2017 fiscal year end cost reports. The rebased rates are contingent upon approval of the state plan amendment by the Centers for Medicare and Medicaid Services.

1. Prospective Rate Calculation.

A. Each nonstate-operated ICF/IID shall have its prospective rate recalculated based on its 2017 fiscal year end cost report using the same principles and methodology as detailed throughout sections (1)-(13) of this regulation.

(I) The costs from the 2017 fiscal year end cost reports shall be trended using the indices from the most recent publication of the Healthcare Cost Review available to the division using the "CMS Nursing Home without Capital Market Basket" table. The costs shall be trended using the four quarter moving average. The costs shall be trended for the years following the cost report year, up to and including the state fiscal year corresponding to the effective date of the rates. For SFY 2019, the trends are as follows:

(a) 2018=3.025%

(b) 2019=2.65%

(II) If a facility's total calculated per diem set forth in this section is less than the facility's current rate, the facility shall continue to receive its current rate.

(III) The division will use the FY 2017 cost report to determine the ICF/IID prospective rate, set forth as follows:

(a) Total Routine Service Cost. Total routine service cost includes patient care, ancillary, dietary, laundry, housekeeping, plant operations, and administration. Each ICF/IID's Title XIX Routine Service Cost per diem shall be calculated as follows:

I. The total routine service costs as reported on the cost report shall be adjusted for minimum utilization, if applicable, trended to the current state fiscal year, and divided by the total patient days to determine the per diem. The minimum utilization adjustment will be determined by applying the unused capacity percent to the sum of the laundry, housekeeping, plant operations, and administration expenses. The following is an illustration of how this item (4)(B)1.A.(III)(a)I. is calculated:

Licensed/Certified Bed Days (9 beds x 365 days)	3,285
Total Patient Days	2,900
Percent Occupied (2,900/3,285)	88%
Bed Days @ Minimum Occupancy of 90% (3,285 x 90%)	2,957
Unused Capacity (90% of Bed Days Less Total Patient Days)	57
Unused Capacity Percent for Minimum Utilization	
Adjustment(Unused Capacity / 90% of Bed Days)	1.93%
Minimum Utilization Days for Return on Owner's Equity(Greater of 90% of Bed Days or Total Patient Days)	2,957

* Minimum Utilization Adjustment	
Laundry	$5,000
Housekeeping	$8,000
Plant Operations	$46,000
Administration	$165,000
Total Expense	$224,000
Unused Capacity Percent	1.93%
Minimum Utilization Adjustment (Unused Capacity Percent x Total Expense)	$4,323
Patient Care	$400,000
Ancillary	$10,000
Dietary	$25,000
Laundry	$5,000
Housekeeping	$8,000
Plant Operations	$46,000
Administration	$165,000
Total Routine Service Cost	$659,000
Less: Minimum Utilization Adjustment	($4,323)
Routine Service Cost, Adjusted for Minimum Utilization	$654,677
SFY 2018 Trend	3.025%
SFY 2019 Trend	2.65%
Trended Routine Service Cost	$692,355
Total Patient Days	2,900
Routine Service Cost Per Diem	$238.74

(b) Intermediate Care Facility for Individuals with Intellectual Disabilities Federal Reimbursement Allowance (ICF/IID FRA). The SFY 2019 ICF/IID FRA provider assessment as determined in accordance with 9 CSR 10-31.030 is divided by total patient days to determine the ICF/IID FRA per diem.

I. The following is an illustration of how the ICF/IID FRA assessment is calculated:

SFY 2019 ICF/IID FRA Assessment	$40,000
Total Patient Days	2,900
ICF/IID FRA Per Diem	$13.79

(c) Return on Equity. An owner's net equity consists of investment capital and working capital as indicated in subsection (6)(S). Each ICF/IID's Return on Equity per diem is calculated as follows:

I. Investment Capital. Investment capital includes the investment in building, property and equipment (cost of land, mortgage payments toward principal and equipment purchase less the accumulated depreciation).

II. Working Capital. Working capital represents the amount of capital which is required to ensure proper operation of the facility and shall be calculated as 1.1 months of the total expenses less depreciation.

III. The total net equity shall be multiplied by the rate of return as set forth in Section (6)(S) to determine the return on equity. The return on equity is subject to the minimum occupancy percent of 90% in determining the per diem.

IV. The following is an illustration of how this item (4)(B)1.A.(III)(c) is calculated:

Investment Capital	Equipment	Building	Total
Cost	$130,000	$300,000	$430,000
Less: Prior Years Depreciation	($120,000)	($225,000)	($345,000)
Less: Current Year Depreciation	($2,400)	($8,500)	($10,900)
Total Investment Capital	$7,600	$66,500	$74,100

Working Capital	
Total Expenses	**$659,000**
Less: Current Year Depreciation Expense	**($10,900)**
	$648,100
Divided by 12 Months	**12**
	$54,008
Times 1.1 Months	
1.1	
Total Working Capital	**$59,409**
Net Equity (Investment Capital + Working Capital)	**$133,509**
Rate of Return	**5.125%**
Return on Equity	**$6,842**
Minimum Utilization Days	**2,957**
Return on Equity Per Diem	**$2.31**

(c) Rebased Per-Diem Rate. The total calculated Per-Diem is the sum of the Routine Service Cost per diem, the ICF/IID FRA per diem and the Return on Equity per diem. To determine the rebased per diem rate, the total calculated per diem is compared to the current per diem rate and the facility will be held harmless if the total calculated per diem is less than the current per diem rate (i.e., if the total calculated per diem is less than the current per diem rate, the facility would receive the current per diem).

Routine Service Cost per diem	**$238.74**
ICF/IID FRA per diem	**$13.79**
Return on Equity per diem	**$2.31**
Total Calculated Per Diem	**$254.84**
Current Per Diem Rate	**$200.00**
Rebased Per Diem Rate	**$254.84**

(If the total calculated per diem is less than the current per diem rate, the facility would receive the current per diem rate)

2. Interim Rate Calculation.

A. In the case of a newly certified facility where a valid Title XIX participation agreement has been executed, a request for an interim rate must be submitted in writing to the MO HealthNet Division.

(I) The interim rate shall be determined based on the projected estimated operating costs. The facility's request must specifically and clearly identify the interim rate and be supported by complete and accurate documentation satisfactory to the single state agency. Documentation submitted must include a budget of the projected estimated operating costs. Other documentation may also be required to be submitted upon the request of the division.

(II) The establishment of the prospective rate for all new construction facility providers shall be based on the second full facility fiscal year cost report (i.e., rate setting cost report) prepared in accordance with the principles of this rule. This cost report shall be based on actual operating costs and shall be prepared and submitted in accordance with the reporting requirements in section (7) of this rule.

(III) Prior to establishment of a prospective rate for newly certified facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services or authorized representative to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this rule.

(IV) The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and a prospective reimbursement rate shall be determined on the allowable per diem cost as set forth in section (4) of this rule. The prospective reimbursement rate shall be effective on the first day of the facility's rate setting cost report and payment adjustments shall be made for claims paid at the interim rate.

*[2.]***3.** Adjustments to rates. The prospectively determined reimbursement rate may be adjusted only under the following conditions:

A. When information contained in a facility's cost report is found to be fraudulent, misrepresented, or inaccurate, the facility's reimbursement rate may be reduced, both retroactively and prospectively, if the fraudulent, misrepresented, or inaccurate information as originally reported resulted in establishment of a higher reimbursement rate than the facility would have received in the absence of this information. No decision by the MO HealthNet agency to impose a rate adjustment in the case of fraudulent, misrepresented, or inaccurate information in any way shall affect the MO HealthNet agency's ability to impose any sanctions authorized by statute or rule. The fact that fraudulent, misrepresented, or inaccurate information reported did not result in establishment of a higher reimbursement rate than the facility would have received in the absence of the information also does not affect the MO HealthNet agency's ability to impose any sanctions authorized by statute or rules;

B. *[In accordance with subsection (6)(B) of this rule, a newly constructed facility's initial reimbursement rate may be reduced if the facility's actual allowable per diem cost for its first twelve (12) months of operation is less than its initial rate;*

C. When a facility's MO HealthNet reimbursement rate is higher than either its private pay rate or its Medicare rate, the MO HealthNet rate will be reduced in accordance with subsection (2)(B) of this rule] **Extraordinary circumstances. A participating facility that has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request should be submitted in writing to the division within one (1) year of the occurrence of the extraordinary circumstance. The request should clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment should be supported by complete and accurate documentation satisfactory to the division. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information may be resubmitted once for the requested rate adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, rate adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:**

*[D.]***(I)** When the provider can show that it incurred higher costs due to circumstances beyond its control, and the circumstances are not experienced by the nursing home or ICF/IID industry in general, **and** the *[request must]* **circumstances** have a substantial cost effect*[. These circumstances include, but are not limited to:]***;**

(II) Extraordinary circumstances, which are beyond the reasonable control of the ICF/IID and are not a product or result of the negligence or malfeasance of the ICF/IID, include:

*[(I)]***(a) Unavoidable** *[A]***a**cts of nature*[, such as]* **are natural wild**fire, earthquakes, **hurricane, tornado, lightning,** *[and flood]* **flooding, or other natural disasters for which no one can be held responsible**, that are not covered by insurance **and that occur in a federally declared disaster area**; **or**

*[(II)]***(b)** Vandalism, civil disorder, or both **that are not covered by insurance**; or

*[(III)]***(c)** Replacement of capital depreciable items not built into existing rates that are the result of circumstances not related to normal wear and tear or upgrading of existing system*[;]***.**

[E. When an adjustment to a facility's rate is made in accordance with the provisions of section (6) of this rule; or

[F.] **C.** When an adjustment is based on an Administrative Hearing Commission or court decision.

D. New, expanded, or terminated services may be subject to rate review.

E. Disallowance of federal financial participation.

F The following will not be subject to review:

(I) The negotiated trend factor;

(II) The use of prospective reimbursement rate; and

(III) The cost base for the per diem rates except as specified in this rule.

[(B) In the case of newly constructed nonstate-operated ICF/IID facilities entering the MO HealthNet program after October 31, 1986, and for which no rate has previously been set, the director or his/her designee may set an initial rate for the facility as in his/her discretion s/he deems appropriate. The initial rate shall be subject to review by the advisory committee under the provisions of section (6) of this rule.]

(5) Covered Services and Supplies.

(A) ICF/IID services and supplies covered by the per diem reimbursement rate under this plan, and which **the ICF/IID** must *[be provided]* **provide**, as required by federal or state law or rule and include, among other services, the regular room, dietary and nursing services, or any other services that are required for standards of participation or certification. Also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service, and enemas;

2. Items *[which]* **that** are furnished routinely and relatively uniformly to all participants, for example, gowns, water pitchers, soap, basins, and bed pans;

3. Items such as alcohol, applicators, cotton balls, bandaids, and tongue depressors;

4. All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners, and nonlegend vitamins. Any nonlegend drug in one (1) of these four (4) categories must be provided to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; *[all must be provided]* **facilities must provide all** as needed within the existing per diem rate;

5. Items which are utilized by individual participants but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable, nondepreciable medical equipment;

6. Additional items as specified in the appendix to this plan when required by the patient;

7. Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, including dietary supplements written as a prescription item by a physician;

8. All laundry services except personal laundry, which is a noncovered service;

9. All general personal care services *[which are furnished]* **that the facility furnishes** routinely and relatively uniformly to all participants for their personal cleanliness and appearance shall be covered services, for example, necessary clipping and cleaning of fingernails and toenails, basic hair care, shampoos, and shaves to the extent necessary for reasonable personal hygiene. The provider shall not bill the patient or his/her responsible party for this type of personal service;

10. All consultative services as required by state or federal law or regulation or for proper operation by the provider. Contracts for the purchase of these services must accompany the provider cost report. Failure to do so will result in the penalties specified in section *[(9)]***(8)** of this rule;

11. Semiprivate room and board and private room and board when necessary to isolate a participant due to a medical or social condition, such as contagious infection, irrational loud speech, and the like. Unless a private room is necessary due to a medical or social condition, a private room is a noncovered service, and a MO HealthNet participant or responsible party may therefore pay the difference between a facility's semiprivate charge and its charge for a private room. MO HealthNet participants may not be placed in private rooms and charged any additional amount above the facility's MO HealthNet per diem unless the participant or responsible party in writing specifically requests a private room prior to placement in a private room and acknowledges that an additional amount not payable by MO HealthNet will be charged for a private room;

12. Twelve (12) days per any period of six (6) consecutive months during which a participant is on a temporary leave of absence from the facility. *[Temporary leave of absence days must be specifically provided for]* **The provider shall specifically provide for temporary leave of absence days** in the participant's plan of care. Periods of time during which a participant is away from the facility because s/he is visiting a friend or relative are considered temporary leaves of absence; and

13. Days when participants are away from the facility overnight on facility-sponsored group trips under the continuing supervision and care of facility personnel.

[(6) Rate Determination. All nonstate-operated ICF/IID providers of LTC services under the MO HealthNet program who desire to have their rates changed or established must apply to the MO HealthNet Division. The department may request the participation of the Department of Mental Health in the analysis for rate determination. The procedure and conditions for rate reconsideration are as follows:

(A) Advisory Committee. The director, Department of Social Services, shall appoint an advisory committee to review and make recommendations pursuant to provider requests for rate determination. The director may accept, reject, or modify the advisory committee's recommendations.

1. Membership. The advisory committee shall be composed of four (4) members representative of the nursing home industry in Missouri, three (3) members from the Department of Social Services, and two (2) members which may include, but are not limited to, a consumer representative, an accountant or economist, or a representative of the legal profession. Members shall be appointed for terms of twelve (12) months. The director shall select a chairman from the membership who shall serve at the director's discretion.

2. Procedures.

A. The committee may hold meetings when five (5) or more members are present and may make recommendations to the department in instances where a simple majority of those present and voting concur.

B. The committee shall meet no less than one (1) time each quarter, and members shall be reimbursed for expenses.

C. The MO HealthNet Division will summarize each case and, if requested by the advisory committee, make recommendations. The advisory committee may request additional documentation as well as require the facility to submit to a comprehensive operational review to determine if there exists an efficient and economical delivery of patient services. The review will be made at the discretion of the committee and may be performed by it or its designee. The findings from a review may be used to determine the per diem rate for the facility. Failure to submit requested documentation shall be grounds for denial of the request.

D. The committee, at its discretion, may issue its recommendation based on written documentation or may request further justification from the provider sending the request.

E. The advisory committee shall have ninety (90) days from the receipt of each complete request, provided the request is on behalf of a facility which has executed a valid Title XIX participation agreement, or the receipt of any additional documentation to submit its recommendations in writing to the director. If the committee is unable to make a recommendation within the specified time limit, the director or his/her designee, if the committee establishes good cause, may grant a reasonable extension.

F. Final determination on rate adjustment. The director's, or his/her designee's, final decision on each request shall be issued in writing to the provider within fifteen (15) working days from receipt of the committee's recommendation.

G. The director's, or his/her designee's, final determination on the advisory committee's recommendation shall become effective on the first day of the month in which the request was made, providing that it was made prior to the tenth of the month. If the request is not filed by the tenth of the month, adjustments shall be effective the first day of the following month;

(B) In the case of new construction where a valid Title XIX participation agreement has been executed, a request for a rate must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total amount involved. The total dollar amount must be supported by complete, accurate, and documented records satisfactory to the single state agency. Until an initial per diem rate is established, the MO HealthNet Division shall grant a tentative per diem rate for that period. In no case may a facility receive a per diem reimbursement rate greater than the class ceiling in effect on March 1, 1990, adjusted by the negotiated trend factor.

1. In the case of newly built facility or part of the facility which is less than two (2) years of age and enters the Title XIX Program on or after November 1, 1986, a reimbursement rate shall be assigned based on the projected estimated operating costs. Advice of the advisory committee will be obtained for all initial rate determination requests for new construction. Owners of new construction which have an approved CON are certified for participation and which have a valid Title XIX participation agreement shall submit a budget in accordance with the principles of section (7) of this rule and other documentation as the committee may request.

2. The establishment of the permanent rate for all new construction facility providers shall be based on the second full facility fiscal year cost report prepared in accordance with the principles of section (7) of this rule. This cost report shall be submitted within ninety (90) days of the close of their second full facility fiscal year. This cost report shall be based on actual operating costs. No request for an extension of this ninety- (90-) day filing requirement will be considered. Any new construction facility provider which fails to timely submit the cost report may be subject to sanction under this rule and 13 CSR 70-3.030.

3. Prior to establishment of a permanent rate for new construction facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this rule.

4. The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and each facility's actual allowable per diem cost will be determined. The cost report shall not be submitted to the advisory committee for review. If a facility's actual allowable per diem cost is less than its initial per diem reimbursement rate, the facility's rate will be reduced to its actual allowable per diem cost. This reduction will be effective on the first day of the second full facility fiscal year.

5. If a facility's actual allowable per diem cost is higher than its initial per diem reimbursement rate, the facility's rate will not be adjusted; a facility shall not receive a rate increase based on review or audit of the cost report and actual operating costs;

(C) In the case of existing facilities not previously certified to participate in the Title XIX program, a request for a per diem reimbursement rate must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total amount involved. The total dollar amount must be supported by complete, accurate, and documented records satisfactory to the single state agency. Until the time as a per diem rate is established, the MO HealthNet Division shall grant a tentative per diem rate for that period. In no case may a facility receive a per diem reimbursement rate greater than the class ceiling in effect on March 1, 1990, adjusted by the negotiated trend factor.

1. In the case of a facility described in subsection (6)(C) of this rule and entering the Title XIX program on or after March 1, 1990, a reimbursement rate shall be assigned based on the projected estimated operating costs. Advice of the advisory committee will be obtained for all initial rate determination requests for first full facility's fiscal year.

2. The establishment of the permanent rate for all existing facility providers shall be based on the second full facility fiscal year cost report prepared in accordance with the principles of section (7) of this rule. This cost report shall be submitted within ninety (90) days of the close of their second full facility fiscal year. This cost report shall be based on actual operating costs. No request for an extension of this ninety- (90-) day filing requirement will be considered. Any new construction facility provider which fails to timely submit the cost report may be subject to sanction under this rule and 13 CSR 70-3.030.

3. Prior to establishment of a permanent rate for existing facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this rule.

4. The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and each facility's actual allowable per diem cost will be determined. The cost report shall not be submitted to the advisory committee for review. If a facility's actual allowable per diem cost is less than its initial per diem reimbursement rate, the facility's rate will be reduced to its actual allowable per diem cost. This reduction will be effective on the second day of the first full facility fiscal year.

5. If a facility's actual allowable per diem cost is higher than its initial per diem reimbursement rate, the facility's rate will not be adjusted; a facility shall not receive a rate increase based on review or audit of the cost report and actual operating costs;

(D) Rate Reconsideration.

1. The committee may review the following conditions for rate reconsideration:

A. Those costs directly related to a change in a facility's case mix; and

B. Requests for rate reconsideration which the director, in his/her discretion, may refer to the committee due to

extraordinary circumstances contained in the request and as defined in subparagraph (4)(A)2.D. of this rule.

2. The request for an adjustment must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by complete, accurate, and documented records satisfactory to the single state agency. The facility must demonstrate that the adjustment is necessary, proper, and consistent with efficient and economical delivery of covered patient care services.

3. However, for state fiscal years after Fiscal Year 1987, in no case may a facility receive a per diem reimbursement rate higher than the class ceiling for that facility in effect on June 30 of the preceding fiscal year adjusted by the negotiated trend factor.

4. The following will not be subject to review:

A. The negotiated trend factor;

B. The use of prospective reimbursement rate; and

C. The cost base for the June 30 per diem rate except as specified in this rule;

(E) Rate Adjustments. The department may alter a facility's per diem rate based on—

1. Court decisions;

2. Administrative Hearing Commission decisions;

3. Determination through desk audits, field audits, and other means, which establishes misrepresentations in or the inclusion of unallowable costs in the cost report used to establish the per diem rate. In these cases, the adjustment shall be applied retroactively; or

4. Adjustments determined by the department without the advice of the rate advisory committee.

A. Prospective payment adjustment (PPA). A FY-92 PPA will be provided prior to the end of the state fiscal year for nonstate-operated ICF/IID facilities with a current provider agreement on file with the MO HealthNet Division as of October 1, 1991.

(I) For providers which qualify, the PPA shall be the lesser of—

(a) The provider's facility peer group factor (FPGF) times the projected patient days (PPD) covered by the adjustment year times the prospective payment adjustment factor (PPAF) times the nonstate-operated intermediate care facility for individuals with intellectual disabilities ceiling (ICFIIDC) on October 1, 1991 (FPGF × PPD × PPAF × ICFIIDC). For example: A provider having nine hundred twenty (920) paid days for the period May 1991 to July 1991 out of a total paid days for this same period of twenty-eight thousand five hundred sixty-one (28,561) represents an FPGF of three and twenty-two hundredths percent (3.22%). So using the FPGF of 3.22% × 114,244 × 24.5% × $156.01 = $140,659; or

(b) The provider FPGF times one hundred forty-five percent (145%) of the amount credited to the intermediate care revenue collection center (ICRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

(II) FPGF—is determined by using each ICF/IID facility's paid days for the service dates in May 1991 through July 1991 as of September 20, 1991, divided by the sum of the paid days for the same service dates for all provider's qualifying as of the determination date of October 16, 1991.

(III) ICFIIDC—is one hundred fifty-six dollars and one cent ($156.01) on October 1, 1991.

(IV) PPAF—is equal to twenty-four and five-tenths percent (24.5%) for fiscal year 1992 which includes an adjustment for economic trends.

(V) PPD—is the projection of one hundred fourteen thousand two hundred forty-four (114,244) patient days made on October 1, 1991, for the adjustment year;

5. FY-92 trend factor and Workers' Compensation. All facilities with either an interim rate or a prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of eight dollars and eighty-six cents ($8.86) per patient day related to the continuation of the FY-92 trend factor and the Workers' Compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/IID facilities; or

6. FY-93 negotiated trend factor. All facilities with either an interim rate or prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of one dollar and sixty-six cents ($1.66) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/IID facilities; and

(F) Rate determination shall be based on a determination of reasonable and adequate reimbursement levels for allowable cost items described in this rule which are related to ordinary and necessary care for the level-of-care provided for an efficiently and economically operated facility. All providers shall submit documentation of expenses for allowable cost areas. The department shall have authority to require those uniform accounting and reporting procedures and forms as it deems necessary. A reasonable and adequate reimbursement in each allowable cost area will be determined by the advisory committee with the consent of the director.]

*[(7)]***(6)** Allowable Cost Areas.

(A) Compensation of Owners.

1. Allowance of compensation of services of owners shall be an allowable cost area, provided the *[services are actually performed]* **owner actually performs the services** and **the services** are necessary *[services]*.

2. **"**Compensation**"** *[shall mean]* **means** the total benefit **to the owner**, within the limitations set forth in this rule, *[by the owner]* of the services s/he renders to the facility *[including]***. Compensation includes** direct payments **to the owner** for managerial, administrative, professional, and other services*[,]***;** amounts paid by the provider for the personal benefit of the owner*[,]***;** the cost of assets and services *[which]* **that** the owner receives from the provider*[,]***;** and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described.

3. *[Reasonableness]* **MO HealthNet auditors may determine the reasonableness** of compensation *[may be determined by]* by reference to or in comparison with compensation paid for comparable institutions or it may be determined by other appropriate means such as the *Medicare and Medicaid Provider Reimbursement Manual* (HIM-15) or by other means.

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility, had the provider not rendered these services, then employment of another person(s) to perform the service would be necessary.

(B) Covered services and supplies as defined in section (5) of this rule.

(C) Depreciation.

1. An appropriate allowance for depreciation on buildings, furnishings, and equipment *[which]* **that** are part of the operation and sound conduct of the provider's business is an allowable cost item.

Finder's fees are not an allowable cost item.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the asset and prorated over the estimated useful life of the asset using the straight-line method of depreciation from the date initially put into service.

3. The basis of assets at the time placed in service shall be the lower of—

A. The book value of the provider;

B. Fair market value at the time of acquisition;

C. The recognized Internal Revenue Service (IRS) tax basis; and

D. In the case of the change in ownership, the cost basis of acquired assets of the owner of record on or after July 18, 1984, as of the effective date of the change of ownership; or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program.

4. The **MO HealthNet Division will allow the** basis of donated assets *[will be allowed]* to the extent of *[recognition of income resulting]* **the recognized income resulting** from the donation of the asset. Should a dispute arise between a provider and the Department of Social Services as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the MO HealthNet program and the facility in ratio to MO HealthNet participant reimbursable patient days to total patient days.

5. Allowable methods of depreciation shall be limited to the straight-line method. The depreciation method used for an asset under the MO HealthNet program need not correspond to the method used by a provider for non-MO HealthNet purposes; however, useful life shall be in accordance with the American Hospital Association's Guidelines. Component part depreciation is optional and allowable under this plan.

6. **"**Historical cost**"** *[is]* **means** the cost incurred by the provider in acquiring the asset and preparing it for use, except as provided in this rule. Usually, historical cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees and related legal fees. Where a provider has elected, for federal income tax purposes, to expense certain items such as interest and taxes during construction, the historical cost basis for MO HealthNet depreciation purposes may include the amount of these expensed items. However, where a provider did not capitalize these costs and has written off the costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For Title XIX purposes and this rule, any asset costing less than five hundred dollars ($500) or having a useful life of one (1) year or less, may be expensed and not capitalized at the option of the provider, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program.

7. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of **the** undepreciated cost basis of the traded asset plus the cash paid.

8. For the purpose of determining allowance for depreciation, the cost basis of the asset shall be as prescribed in paragraph *[(7)]***(6)**(C)3.

9. Capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a provider's bed capacity shall not be allowed in the program or depreciation base if these capital expenditures fail to comply with any other federal or state law or regulation, such as Certificate of Need (CON).

10. Amortization of leasehold rights and related interest and finance costs shall not be allowable costs under this plan.

(D) Interest and Finance Costs.

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost item excluding finder's fees.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for those purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as **the** acquisition of facilities and capital improvements, and this indebtedness must be amortized over the life of the loan.

3. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. To be an allowable cost item, interest (including finance charges, prepaid costs, and discounts) must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required, identifiable in the provider's accounting records, relating to the reporting period in which the costs are claims, and necessary and proper for the operation, maintenance, or acquisition of the provider's facilities.

5. Necessary means that the interest be incurred for a loan made to satisfy a financial need of the provider and for a purpose related to participant care. Loans *[which]* **that** result in excess funds or investments are not considered necessary.

6. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made, and provided further the department shall not reimburse for interest and finance charges any amount in excess of the prime rate current at the time the loan was obtained.

7. Interest on loans to providers by proprietors, partners, and any stockholders shall not be an allowable cost item because the loans shall be treated as invested capital and included in the computation of an allowable return on owner's net equity. If a facility operated by a religious order borrows from the order, interest paid to the order shall be an allowable cost.

8. If loans for capital indebtedness exceed the asset cost basis as defined in subsection *[(7)]***(6)**(C) of this rule, the interest associated with the portion of the loan(s) which exceed the asset cost basis as defined in subsection *[(7)]***(6)**(C) of this rule shall not be allowable.

9. Income from a provider's qualified retirement fund shall be excluded in consideration of the per diem rate.

10. A provider shall amortize finance charges, prepaid interest, and discount over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance.

11. Usual and customary costs, excluding finder's fees, incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the loan period ratably or by means of the constant interest applied method.

12. Usual and customary costs shall be limited to the lender's title and recording fees, appraisal fees, legal fees, escrow fees, and closing costs.

13. Interest expense resultant from capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a bed capacity by the provider shall not be an allowable cost item if the capital expenditure fails to comply with other federal or state law or rules such as CON.

(E) Rental and Leases.

1. Rental and leases of land, buildings, furnishings, and equipment are allowable cost areas *[provided that]* **if** the rented items are necessary and not in essence a purchase of those assets. Finder's fees are not an allowable cost item.

2. Necessary rental and lease items are those *[which]* **that** are pertinent to the economical operation of the provider.

3. In the case of related parties, rental and lease amounts cannot exceed the lesser of those *[which]* **that** are actually paid or the costs to the related party.

4. Determination of reasonable and adequate reimbursement for rental and amounts, except in the case of related parties *[which]* **that** is subject to other provisions of this rule, may require affidavits of

competent, impartial experts who are familiar with the current rentals and leases.

5. The test of necessary costs shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

6. Leases subject to CON approval must have that approval before a rate is determined.

7. If rent or lease costs increase solely as a result of change in ownership, the resulting increase which exceeds the allowable capital cost of the owner of record as of July 18, 1984, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program, shall be a nonallowable cost.

(F) Taxes. Taxes levied on or incurred by providers shall be allowable cost areas with the exceptions of the following items:

1. Federal, state, or local income and excess profit taxes including any interest and penalties paid;

2. Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bond, property transfer, issuance of transfer of stocks;

3. Taxes for which exemptions are available to the provider;

4. Special assessments on land *[which]* **that** represent capital improvements. These costs shall be capitalized and depreciated over the period during which the assessment is scheduled to be paid;

5. Taxes on property which are not a part of the operation of the provider;

6. Taxes which are levied against a resident and collected and remitted by the provider; and

7. Self-employment Federal Insurance Contributions Act (FICA) taxes applicable to individual proprietors, partners, or members of a joint venture to the extent the taxes exceed the amount which would have been paid by the provider on the allowable compensation of the persons had the provider organization been an incorporated rather than unincorporated entity.

(G) Issuance of Revenue Bond and Tax Levies by District and County Facilities. Those nursing home districts and county facilities whose funding is through the issuance of revenue bonds, that interest which is paid per the revenue bond will be an allowable cost item. Depreciation on the plant and equipment of these facilities also shall be an allowable cost item. Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset except to the extent that the funds are used for the actual operation of the facility.

(H) Value of Services of Employees.

1. Except as provided for in this rule, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers, such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals, and similar organizations, shall not be included as an allowable cost area, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis, and similar type professionals shall be an allowable cost area; provided, that the services are not of a religious nature. An example of an allowable cost area under this section would be a necessary administrative function performed by a clergyman. The state will not recognize building costs on space set aside primarily for professionals providing any religious function. *[Costs]* **The MO HealthNet Division considers costs** for wardrobe and similar items likewise *[are considered]* nonallowable.

(I) Fringe Benefits.

1. Life insurance.

A. Types of insurance *[which are not considered]* **that the MO HealthNet Division does not consider** an allowable cost area; premiums related to insurance on the lives of officers and key employees are not allowable cost areas under the following circumstances:

(I) Where, upon the death of an insured officer or key employee, the insurance proceeds are payable directly to the provider. In this case, the provider is a direct beneficiary. Insurance of this type is referred to as key-man insurance; and

(II) Where insurance on the lives of officers is voluntarily taken out as part of a mortgage loan agreement entered into for building construction and, upon the death of an insured officer, the proceeds are payable directly to the lending institution as a credit against the loan balance. In this case, the provider is an indirect beneficiary.

B. Types of insurance which are considered an allowable cost area—

(I) Where credit life insurance is required as part of a mortgage loan agreement. An example would be insurance on loans granted under certain federal programs; and

(II) Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. *[This type of insurance is considered to be]* **The MO HealthNet Division considers this type of insurance** a fringe benefit and is an allowable cost area to the extent that the amount of coverage is reasonable.

2. Retirement plans.

A. Contributions to qualified retirement plans for the benefit of employees excluding stockholders, partners, and proprietors of the provider shall be allowable cost areas. *[Interest]* **Facilities shall exclude interest** income from funded pensions or retirement plans *[shall be excluded]* from consideration in determining the allowable cost area.

B. Amounts funded to pension and retirement plans, together with associated income, shall be recaptured if not actually paid when due, as an offset to expenses on the cost report form.

3. Deferred compensation plans.

A. Contributions for the benefit of employees, excluding stockholders, partners, and proprietors, under deferred compensation plans shall be all allowable cost areas when, and to the extent that, the costs are actually paid by the provider. Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans will be considered as an allowable cost area only when paid to the participating employee and only to the extent considered reasonable.

B. Amounts paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans, together with associated income [shall be recaptured] if not actually paid when due, as an offset to expenses on the cost report form.

(J) Education and Training Expenses.

1. The cost of on-the-job training *[which]* **that** directly benefits the quality of health care or administration at the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is an allowable cost item only when specifically authorized in advance by the department.

2. Cost of education and training shall include incidental travel costs, but will not include leaves of absence or sabbaticals.

(K) Organizational Cost Items.

1. Organizational cost items may be included as an allowable cost area on an amortized basis.

2. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations, necessary accounting fees, expenses of temporary directors, and organizational meetings of directors and stockholders, and fees paid to states of incorporation.

3. *[Organizational costs shall be amortized]* **The provider shall amortize organizational costs** ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the

date of organization, no organizational costs shall be recognized.

4. Where a provider did not capitalize organizational costs and has written off those costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program.

5. Where a provider is organized within a five- (5-) year period prior to entering the program and has properly capitalized organizational costs using a sixty- (60-) month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost area under the program and shall be amortized over the remaining part of the sixty- (60-) month period.

6. For change in ownership after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost.

(L) Advertising Costs. Advertising costs *[which]* **that** are reasonable, appropriate, and helpful in developing, maintaining, and furnishing services shall be an allowable cost area. The costs must be common and accepted occurrence in the field of the activity of the provider.

(M) Cost of Suppliers Involving Related Parties. Costs applicable to facilities, goods, and services furnished to a provider by a supplier related to the provider shall not exceed the lower of the cost to the supplier or the prices of comparable facilities, goods, or services obtained elsewhere. A provider shall identify suppliers related to it in the uniform cost report and the type-quantity and costs of facilities, goods, and services obtained from each supplier.

(N) Utilization Review. Incurred cost for the performance of required utilization review for ICF/IID is an allowable cost area. The expenditures must be for *[the purpose of]* providing utilization review on behalf of a Title XIX participant. *[Utilization]* **The provider shall apportion utilization** review costs incurred for Title XVIII and Title XIX *[must be apportioned on the basis of]* **based on** reimbursable participant days recorded for each program during the reporting period.

(O) Minimum Utilization. In the event the occupancy of a provider is below ninety percent (90%), the **provider will calculate the** following cost centers *[will be calculated]* as if the provider experienced ninety percent (90%) occupancy: laundry, housekeeping, general, administrative, and plant operation costs. In no case may **the provider carry forward** costs disallowed under this provision *[be carried forward]* to succeeding periods.

(P) Nonreimbursable Costs.

1. Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included as allowable costs.

2. Those services that are specifically provided by Medicare and MO HealthNet must be billed to those agencies.

3. Any costs incurred that are related to fund drives are not reimbursable.

4. Costs incurred for research purposes shall not be included as allowable costs.

5. The cost of services provided under the Title XX program, by contract or subcontract, is specifically excluded as an allowable item.

6. Attorney fees related to litigation involving state, local, or federal governmental entities and attorneys' fees which are not related to the provision of LTC services, such as litigation related to disputes between or among owners, operators, or administrators.

7. Costs, such as legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition of merger for which any payment has been previously made under the program.

(Q) Other Revenues. Other revenues, including those listed that follow and excluding amounts collected under paragraph (5)(A)8. will be deducted from the total allowable cost and must be shown separately in the cost report by use of a separate schedule if included in the gross revenue: income from telephone services; sale of employee and guest meals; sale of medical abstracts; sale of scrap and waste food or materials; rental income; cash, trade, quantity time, and other discounts; purchase rebates and refunds; recovery on insured loss; parking lot revenues; vending machine commissions or profit; sales from drugs to other than participants; income from investments of whatever type; and room reservation charges for temporary leave of absence days which are not covered services under section (5) of this rule. Failure **by the provider** to**, in a readily ascertainable manner,** separately account for any of the revenues specifically set out previously *[in this rule in a readily ascertainable manner]* **in this rule,** shall result in **the provider's** termination from the program.

1. Interest income received from a funded depreciation account will not be deducted from allowable operating costs *[provided that]* **if** interest is applied to the replacement of the asset being depreciated.

2. Cost centers or operations specified by the provider in paragraph *[(7)(R)3.]* **(6)(R)** of this rule shall not have their associated cost or revenues included in the covered costs or revenues of the facility.

3. Restricted and unrestricted funds.

A. **"**Restricted funds**,"** as used in this rule**,** mean those funds, cash or otherwise, including grants, gifts, taxes, and income from endowments, which **the provider** *[must be used only]* **shall only use** for a specific purpose designated by the donor. Those restricted funds *[which]* **that** are not transferred funds and are designated by the donor for paying operating costs will be offset from the total allowable expenses. If an administrative body has the authority to re-restrict restricted funds designated by the donor for paying operating costs, the *[funds]* **provider** will not *[be]* offset **the funds** from **the** total allowable expenses.

B. **"**Unrestricted funds**,"** as used in this rule**,** mean those funds, cash or otherwise, including grants, gifts, taxes, and income from endowments, that *[are given]* **a donor gives** to a provider without restriction *[by the donor]* as to their use. *[These funds can be used]* **The provider can use these funds** in any manner *[desired by the provider]*. However, those unrestricted funds *[which]* **that** are not transferred funds and *[are used for paying]* **that the provider uses to pay** operating costs will be offset from total allowable expenses.

C. Transferred funds as used in this rule are those funds appropriated through a legislative or governmental administrative body's action, state or local, to a state or local government provider. The transfer can be state-to-state, state-to-local, or local-to-local provider. *[These funds are not considered]* **The MO HealthNet Division does not consider these funds** a grant or gift for reimbursement purposes, so *[having]* **have** no effect on the provider's allowable cost under this plan.

(R) Apportionment of Costs to MO HealthNet Participant Residents.

1. *[Provider's]* **Providers shall apportion their** allowable cost areas *[shall be apportioned]* between MO HealthNet program participant residents and other *[patients]* **residents** so that the share **of allowable cost areas** borne by the MO HealthNet program is based upon actual services received by **MO HealthNet** program participants.

2. To accomplish this apportionment, **providers shall apply** the ratio of *[participant residents' charges]* **patient days for MO HealthNet participants** to **the** total patient *[charges for the service of each ancillary department may be applied to the cost of this department. To this shall be added the cost of routine services for MO HealthNet program participant residents determined on the basis of a separate average cost per diem for general routine care areas or at the option of the provider on the basis of overall routine care area.*

3. So that its charges may be allowable for use in apportioning costs under the program, each provider shall have an established charge structure which is applied uniformly to

each patient as services are furnished to the patient and which is reasonable and consistently related to the cost of providing these services] **days.**

*[4.]***3.** Average cost per diem for general routine services means the amount computed by dividing the total allowable patient costs for routine services by the total number of patient days of care rendered by the provider in the cost-reporting period.

*[*5.*]***4.** A patient day of care is that period of service rendered a patient between the census-taking hours on two (2) consecutive days, including the twelve (12) temporary leave of absence days per any period of six (6) consecutive months as specifically covered under section (5) of this rule, the day of discharge being counted only when the patient was admitted the same day. *[A census log shall be maintained]* **The provider shall maintain a census log** in the facility for documentation purposes. Census shall be taken daily at midnight. A day of care includes those overnight periods when a participant is away from the facility on a facility-sponsored group trip and remains under the supervision and care of facility personnel.

*[6.]***5.** ICF/IID facilities that provide intermediate care services to MO HealthNet participants may establish distinct part cost centers in their facility provided that adequate accounting and statistical data required to separately determine the nursing care cost of each distinct part is maintained. Each distinct part may share the common services and facilities, such as management services, dietary, housekeeping, building maintenance, and laundry.

*[7.]***6.** In no case may a provider's allowable costs allocated to the MO HealthNet program include the cost of furnishing services to persons not covered under the MO HealthNet program.

(S) Return on Equity.

1. A return on a provider's net equity shall be an allowable cost area.

2. The amount of return on a provider's net equity shall *[not exceed twelve percent (12%)]* **be calculated using the nursing home allowable percentage as defined in 13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services**.

3. An owner's net equity is comprised of investment capital and working capital. Investment capital includes the investment in building, property, and equipment (cost of land, mortgage payments toward principle, and equipment purchase less the accumulative depreciation). Working capital represents the amount of capital *[which]* **that** is required to *[insure]* **ensure** proper operation of the facility.

4. The return on owner's net equity shall be payable only to proprietary providers.

5. *[A provider's]* **The provider shall apportion its** return on **the** owner's net equity *[shall be apportioned]* to the MO HealthNet program *[on the basis of]* **based on** the provider's MO HealthNet program reimbursable participant resident days of care to total resident days of care during the cost-reporting period. For the purpose of this calculation, total resident days of care shall be the greater of ninety percent (90%) of the provider's certified bed capacity or actual occupancy during the cost year.

(T) Intermediate Care Facility for Individuals with Intellectual Disabilities Federal Reimbursement Allowance (ICF/IID FRA). The fee assessed to ICF/IIDs in the state of Missouri for the privilege of doing business in the state will be an allowable cost.

*[(8)]***(7)** Reporting Requirements.

(A) Annual Cost Report.

1. Each provider shall establish a twelve- (12-) month fiscal period which is to be designated as the provider's fiscal year. *[An]* **The provider shall submit an** annual cost report for the fiscal year *[shall be submitted by the provider]* to the department on forms to be furnished **by the department** for that purpose. *[The]* **Each provider shall submit the** completed cost report *[shall be submitted by each provider]* **by** the first day of the sixth month following the close of the fiscal period.

2. Unless **the provider has previously filed** adequate and current documentation in the following areas *[has been filed previously]* with the department, authenticated copies of the following documents must be submitted **by the provider** with the cost reports: authenticated copies of all leases related to the activities of the facility; all management contracts, all contracts with consultants; federal and state income tax returns for the fiscal year; and documentation of expenditures, by line item, made under all restricted and unrestricted grants. For restricted grants, a statement verifying the restriction as specified by the donor.

3. *[Adequate]* **The facility shall maintain adequate** documentation for all line items on the uniform cost reports *[must be maintained by the facility]* and must *[be submitted]* **submit the document** to the department upon request.

4. If a cost report is more than ten (10) days past due, payment *[shall]* **may** be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this regulation, **the department will release** the **withheld** payments *[that were withheld will be released]* to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's MO HealthNet participation agreement and if terminated, retain all payments which have been withheld pursuant to this provision.

5. If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division *[will]* **may** withhold all remaining payments from the selling provider until **the provider files** the cost report *[is filed]*. The fully completed cost report with all required attachments and documentation is due the first day of the sixth month after the date of change of control, ownership, or termination. Upon receipt of a cost report prepared in accordance with this regulation, **the department will release** any **withheld** payment *[that was withheld will be released]* to the selling provider.

(B) Certification of Cost Reports.

1. *[The]* **The facility must certify the** accuracy and validity of any cost report *[must be certified]*. Certification must be made by one (1) of the following persons (who must be authorized by the governing body of the facility to make the certification and will furnish proof of the authorization): an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner; or for a public facility, the chief administrative officer of the facility. The cost report must also be notarized by a licensed notary public.

2. Certification statement.

Form of Certification

Misrepresentation or falsifications of any information contained in this report may be punishable by fine, imprisonment, or both, under state or federal law.

Certification by officer or administrator of provider:

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by _____

_____

(Provider's name(s) and number(s))

for the cost report period beginning,

_____, 20_____ and ending _____, 20_____, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

_____ _____ _____

(Signature) *(Title)* *(Date)*

(C) Adequacy of Records.

1. The provider must make available to the department or its duly authorized agent, including federal agents from Health and Human Services (HHS), at all reasonable times, the records as are necessary to permit review and audit of provider's cost reports.

Failure to do so may lead to sanctions *[stated in section (8) of this rule or other sanctions]* available in section *[(9)]* **(8)** of this rule.

2. *[All]* **The provider shall retain all** records associated with the preparation and documentation of the data associated with the cost report *[must be retained]* for seven (7) years from the cost report filing date.

(D) Accounting Basis.

1. *[The]* **The provider shall base the submitted** cost report *[submitted must be based]* on the accrual basis of accounting.

2. Governmental institutions that operate on a cash or modified cash basis of accounting may continue to use those methods, provided *[appropriate treatment of capital expenditures is made]* **the governmental institution treats capital expenditures appropriately**.

(E) Audits.

1. *[Cost reports shall be based]* **The provider shall base cost reports** upon the provider's financial and statistical records *[which]* **that** must be capable of verification by audit.

2. If the provider has included the cost of a certified audit of the facility as an allowable cost item to the plan, a copy of that audit report and accompanying letter shall be submitted without deletions.

3. The annual cost report for the fiscal year of the provider may be subject to audit by the Department of Social Services or its contracted agents. Twelve- (12-) month cost reports for new construction facilities required to be submitted under section (4) of this rule may be audited by the department or its contracted agents prior to establishment of a permanent rate.

4. The department **or authorized agent** will conduct a desk review of all cost reports after submission by the provider and shall provide for on-site audits of facilities wherever **their personnel note** cost variances or exceptions *[are noted by their personnel]*.

5. The department shall retain the annual cost report and any working papers relating to the audits of those cost reports for a period of not less than seven (7) full years from the date of submission of the report or completion of the audit.

6. Those providers having an annual Title XIX bed-day ratio on total bed days or certified beds of greater than sixty percent (60%) or an annual Title XIX payment of two hundred thousand dollars ($200,000) or more, or both, shall be required, for at least the first two (2) fiscal years of participation in the plan, to have an annual audit of their financial records by an independent certified public accountant. The auditor may issue a qualified audit report stating that confirmations of accounts receivable and accounts payable are not required by the plan. For the purposes of the paragraph, the Department of Social Services will only accept an unqualified opinion from a certified public accounting firm. A copy of the audit report must be submitted to the department to support the annual cost report of the facility.

*[(9)]***(8)** Sanctions and Overpayments.

(A) *[Sanctions may be imposed]* **The department may impose sanctions** against a provider in accordance with 13 CSR 70-3.030 and other federal or state statutes and regulations.

(B) In the case of overpayments to providers based on, but not limited to, field or audit findings or determinations based on a comprehensive operational review of the facility, the provider shall repay the overpayment in accordance with the provisions as set forth in 13 CSR 70-3.030.

*[(10)]***(9)** Exceptions.

(A) For those MO HealthNet-eligible participant-patients who have concurrent Medicare Part A skilled nursing facilities benefits available, MO HealthNet reimbursement for covered days of stay in a qualified facility will be based on the coinsurance as may be imposed under the Medicare Program.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided **prior authorized** services of fewer than one thousand (1,000) patient days for Missouri Title XIX participants, the reimbursement rate shall be the rate paid for comparable services and level-of-care by the state in which the provider is located; and

2. For providers *[which]* **that** provide **prior authorized** services of one thousand (1,000) or more patient days for Missouri Title XIX participants, the reimbursement rate shall be the lower of—

A. The rate paid for comparable services and level-of-care by the state in which the provider is located; or

B. The rate calculated in *[sections (4) and (6)]* **section (4)** of this rule.

*[(11)]***(10)** Payment Assurance.

(A) The state will pay each provider, which furnished the services in accordance with the requirements of the state plan, the amount determined for services furnished by the provider according to the standards and methods set forth in these rules.

(B) Where third-party payment is involved, MO HealthNet will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Service. Procedures for remitting third-party payments are provided in the MO HealthNet program provider manuals.

*[(12)]***(11)** Provider Participation. Payments made in accordance with the standards and methods described in this rule are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive medical care and services included in the state plan at least to the extent these services are available to the general public.

*[(13)]***(12)** Payment in Full. Participation in the program shall be limited to providers who accept as payment in full for covered services rendered to MO HealthNet participants, the amount paid in accordance with these rules and applicable copayments.

*[(14)]***(13)** Plan Evaluation. *[Documentation will be maintained]* **The provider will maintain documentation** to effectively monitor and evaluate experience during administration of this rule.

AUTHORITY: sections 208.153, 208.159, 208.201, and 660.017, RSMo 2016. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2019, effective Nov. 8, 2019, expires May 5, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will cost state agencies or political subdivisions approximately $1,023,030 in the time the emergency is effective.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the time the emergency is effective.

FISCAL NOTE
PUBLIC COST

I. Department Title: Title 13 – Department of Social Services
Division Title: Division 70 – MO HealthNet Division
Chapter Title: Chapter 10 – Nursing Home Program

Rule Number and Name:	13 CSR 70-10.030 Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/IID Services
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Mental Health	Cost for the time period the emergency amendment is effective is approximately $1,023,030

III. WORKSHEET

The annual cost of the rate rebase is approximately $818,421. The rate rebase is effective January 1, 2019; thus, the cost for the time period the emergency is effective is $1,023,030.

Nonstate Operated ICF/IIDs	Estimated Days	Est. Rate Increase/ Hold Harmless *	Estimated Impact
Facility 1	3,172	$ 33.51	$ 106,294
Facility 2	2,671	$ 69.87	$ 186,623
Facility 3	2,342	$ 78.08	$ 182,863
Facility 4	11,429	$ 29.98	$ 342,641
Facility 5	3,283	$ 0.00	$ 0.00
Facility 6	3,285	$ 0.00	$ 0.00
Facility 7	2,652	$ 0.00	$ 0.00
Total Annual Days / Cost	28,834		$ 818,421
Divided by 12 Months			12
Monthly Cost			$ 68,202
Months Paid in the Time the Emergency is Effective: January 2019 - March 2020			15
Cost in the Time the Emergency is Effective			$1,023,030

* Facilities that are "Hold Harmless" will not receive a rate increase but will continue to receive their current rate. See IV. Assumptions below for additional information.

IV. ASSUMPTIONS

The rebased rates are based on 2017 cost report data trended to 2019, the year that the rates become effective. A facility whose preliminary, recalculated rate is less than its current rate will continue to receive its current rate (i.e., Hold Harmless).

The estimated days are from the 2017 data. Since the nonstate-operated ICF/IIDs have a stable census from year to year, the days from the 2017 base year do not require a utilization adjustment.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (3), (5), and (13).

PURPOSE: This amendment revises plan change criteria for Medicare Advantage Plan members, default enrollment procedures, clarifies disabled dependent eligibility, reporting of other health coverage, and renumbers as necessary.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov or through another designated enrollment system within thirty-one (31) days of his/her hire date or the date the employer notifies the employee that s/he is an eligible variable-hour employee. If enrolling a spouse or child(ren), proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect, change, or cancel coverage for the next plan year during the annual open enrollment period that runs October 1 through October 31 of each year.

3. An active employee may elect or change coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. An employee or his/her spouse/child(ren) may enroll within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a child, the active employee may enroll the child in an MCHCP plan within sixty (60) days of the court order.

4. Default enrollment.

A. If an active employee is enrolled in the PPO *[300 or]* **750,** PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled **in the same plan enrolled in the prior year** at the same level of coverage *[in the PPO 1250 Plan provided through the vendor the employee is enrolled in, effective the first day of the next calendar year]*.

[B. If an active employee is enrolled in the Health Savings Account (HSA) Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the HSA Plan at the same level of coverage.]

*[C.]***B.** If an active employee is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

*[D.]***C.** Married state employees who are both MCHCP members who do not complete enrollment during the open enrollment period, will continue to meet one (1) family deductible and out-of-pocket maximum if they chose to do so during the previous plan year.

*[E.]***D.** If an active employee is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents or spouse/child(ren) at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date even if the retiree is continuing coverage as a variable-hour employee after retirement. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment, but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. A retiree enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage;" and

C. Not a Qualified Medicare Beneficiary.

*[5.]***6.** Default enrollment.

A. A retiree with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the retiree or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the retiree **is not able to be enrolled in the Medicare Advantage Plan,** *[does not have Medicare Part B, and does not complete enrollment during the open enrollment period,]* the retiree and his/her dependents without Medicare will be enrolled in the *[PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]* **same plan enrolled in the prior year at the same level of coverage.**

B. If a retiree with Medicare **has a non-Medicare dependent** *[is]* enrolled in the PPO *[300]* **750**, *[or]* PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, *[and has dependents who are not covered by Medicare]*, his/her dependents without Medicare will be enrolled in *[the PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* **the same plan enrolled in the prior year with the same level of coverage**.

C. If a retiree without Medicare is enrolled in the PPO *[300]* **750**, *[or]* PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

[D. If a retiree without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the retiree is enrolled in at the same level of coverage, effective the first day of the next calendar year.]

*[E.]***D.** If a retiree without Medicare is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage, effective the first day of the next calendar year.

*[6.]***7.** If a retiree is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

*[7.]***8.** If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. A terminated vested member enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage;" and

C. Not a Qualified Medicare Beneficiary.

*[3.]***4.** Default enrollment.

A. A terminated vested subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the terminated vested subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the terminated vested subscriber *[does not have Medicare Part B, and does not complete enrollment during the open enrollment period]* **is not able to be enrolled in the Medicare Advantage Plan**, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

B. If a terminated vested subscriber without Medicare is enrolled in the PPO *[300]* **750,** *[or]* PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

[C. If a terminated vested subscriber without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the terminated vested subscriber is enrolled in effective the first day of the next calendar year, at the same level of coverage.]

*[D.]***C.** If a terminated vested subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

*[E.]***D.** If a terminated vested subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

*[4.]***5.** If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. A long-term disability member enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage;" and

C. Not a Qualified Medicare Beneficiary.

*[3.]***4.** Default enrollment.

A. A long-term disability subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the long-term disability subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the long-term disability subscriber *[does not have Medicare Part B, and does not complete enrollment during the open enrollment period]* **is not able to be enrolled in the Medicare Advantage Plan**, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

B. If a long-term disability subscriber without Medicare is enrolled in the PPO *[300]* **750,** *[or]* PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the long-term disability subscriber is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

C. If a long-term disability subscriber with Medicare *[is]* **has a non-Medicare dependent** enrolled in the PPO *[300]* **750,** *[or]* PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period *[and has dependents who are not covered by Medicare]*, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* **the same plan enrolled in the prior year with the same level of coverage**.

[D. If a long-term disability subscriber without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the long-term disability subscriber is enrolled in at the same level of coverage, effective the first day of the next calendar year.]

*[E.]***D.** If a long-term disability subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

*[F.]***E.** If a long-term disability subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

*[4.]***5.** If a long-term disability subscriber submits an Open

Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

1. A survivor **without Medicare** must submit a survivor enrollment form *[and a copy of the death certificate]*within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor with Medicare will be automatically enrolled as a survivor following the death of the employee.

*[2.]***3.** A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

*[3.]***4.** A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. A survivor enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage;" and

C. Not a Qualified Medicare Beneficiary.

*[4.]***6.** Default enrollment.

A. A survivor with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the survivor or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the survivor *[does not have Medicare Part B, and does not complete enrollment during the open enrollment period]* **is not able to be enrolled in the Medicare Advantage Plan**, the survivor and his/her dependents without Medicare will be enrolled in the *[PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

B. If a survivor without Medicare is enrolled in the PPO *[300]* **750,** *[or]* PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the survivor is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

C. If a survivor with Medicare has a non-Medicare dependent *[is]* enrolled in the PPO *[300]* **750,** *[or]* PPO *[600]* **1250**, **or HSA** Plan and does not complete enrollment during the open enrollment period *[and has dependents who are not covered by Medicare]*, the survivor and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

[D. If a survivor without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the survivor is enrolled in at the same level of coverage, effective the first day of the next calendar year.]

*[E.]***D.** If a survivor without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

*[F.]***E.** If a survivor is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

*[5.]***7.** If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(G) Disabled Dependent.

1. A**n** *[new]* employee may enroll his/her permanently disabled child **when first eligible** or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the end of the month of the

dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of *[a new employee and his/her]* **the** permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or will never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(13) Members are required to disclose to the claims administrator whether or not they have other health coverage and, if so, information about the coverage. *[A member may submit this information to the claims administrator by phone, fax, mail, or online. Dependent claims will be denied if the disclosure is not made.]* Once the information is received, claims will be reprocessed subject to all applicable rules.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RESCISSION

22 CSR 10-2.045 Plan Utilization Review Policy. This rule established the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes due to a new third party administrator.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rescission complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan Medical Plans.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling

governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization—The claims administrator must authorize some services in advance. Preauthorization is to determine if the procedure or treatment is medically necessary. The claims administrator will determine what procedures or treatments are subject to preauthorization. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, or who are enrolled in the Medicare Advantage Plan are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. A list of medical services for which preauthorization is required may be obtained at any time from the claims administrator.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization requests will be made within thirty-six (36) hours, which will include one (1) business day of the receipt of the request. If the information necessary to make a benefit determination is not received, the claims administrator will notify the member and provider of any necessary extension. The provider will be given forty-five (45) calendar days from receipt of the extension notice to respond with additional information. Once the information is received or the forty-five (45) days have elapsed, a determination will be made within thirty-six (36) hours which will include one (1) business day.

B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than one (1) business day of the receipt of all necessary information;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision;

(C) Retrospective Review—Reviews to determine coverage after services have been provided to a member. The retrospective review is not limited to an evaluation of medical necessity, reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment. The claim administrator shall have the authority to correct payment errors when identified under retrospective review;

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment; and

(E) Case Management—A voluntary process to assess, coordinate, and evaluate options and services of members with catastrophic and complex illnesses. A case manager will help members understand what to expect during the course of treatment, help establish collaborative goals, complete assessments to determine needs, interface with providers, and negotiate care. Members are identified for case management through claim information, length of hospital stay, or by referral. The case manager will dismiss the member from case management once the case manager determines that objectives have been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed rescission and rule covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (5), (11), (12), and (14).

PURPOSE: This amendment adds one hundred percent (100%) coverage for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, and services performed in another country for the PPO 750 Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help

protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; *[and]*

(D) Four (4) Diabetes Self-Management Education visits*[.]***; and**

(E) Sterilization procedure for men.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claim administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service, **unless other specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.047 PPO 1250 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (5), (11), (12), and (14).

PURPOSE: This amendment adds one hundred percent (100%) coverage for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, and services performed in another country for the PPO 1250 Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; *[and]*

(D) Four (4) Diabetes Self-Management Education visits*[.]***; and**

(E) Sterilization procedure for men.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claim administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service**, unless other specified in the network provider contract**. The plan reserves the right to deny claims not

timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (3), (14), (15), (17), and adding section (9).

PURPOSE: This amendment revises the Health Savings Account (HSA) Plan individual family member out-of-pocket maximum, adds one hundred percent (100%) coverage after deductible is met for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, services performed in another country, and renumbers as necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—four thousand nine hundred fifty dollars ($4,950);

2. Network out-of-pocket maximum for family—nine thousand nine hundred dollars ($9,900). Any individual family member need only incur a maximum of *[seven thousand nine hundred dollars ($7,900)]* **eight thousand one hundred fifty dollars ($8,150)** before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual—nine thousand nine hundred dollars ($9,900); and

4. Non-network out-of-pocket maximum for family—nineteen thousand eight hundred dollars ($19,800).

(9) Sterilization procedure for men is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

*[(9)]***(10)** Newborn's claims will be subject to deductible and coinsurance.

*[(10)]***(11)** Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

*[(11)]***(12)** Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

*[(12)]***(13)** Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

*[(13)]***(14)** Maximum plan payment—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the**

claim administrator's standard practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

*[(14)]***(15)** Any claim must be initially submitted within twelve (12) months following the date of service**, unless other specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

*[(15)]***(16)** For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

*[(16)]***(17)** Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

*[(17)]***(18)** An active employee subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (19) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare (unless Medicare is secondary coverage to MCHCP);

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-purpose health FSA, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

*[(18)]***(19)** If an active employee subscriber and/or his/her dependent(s) is enrolled in the HSA Plan and becomes ineligible for the HSA Plan during the plan year, the subscriber and/or his/her dependent(s) will be enrolled in the PPO 1250 Plan. The subscriber may enroll in a different non-HSA Plan within thirty-one (31) days of notice from MCHCP.

*[(19)]***(20)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

*[(20)]***(21)** Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the subscriber must be an active employee and HSA eligible as defined in the Internal Revenue Service Publication 969 on the date the contribution is made and open an HSA with the bank designated by MCHCP.

1. Subscribers who enroll in the HSA Plan during open enrollment who have a balance in a health care FSA on January 1 of the new plan year cannot receive an HSA contribution from MCHCP until after the health care FSA grace period ends March 15.

(B) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP contribution will receive an applicable prorated contribution. Unless a subscriber is eligible for a special enrollment period, a subscriber will not be able to voluntarily change his/her plan selection.

(C) A subscriber who moves from subscriber-only coverage to another coverage level with an effective date after the MCHCP contribution will receive an applicable prorated contribution based on the increased level of coverage.

(D) If a subscriber moves from another coverage level to subscriber-only coverage, cancels all coverage, or MCHCP terminates coverage and has received an HSA contribution, MCHCP will not request a re-payment of the contribution.

(E) If both spouses are state employees covered by MCHCP and they both enroll in an HSA Plan, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars ($600) regardless of the number of HSAs or the number of children covered under the HSA Plan for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a maximum three hundred dollar ($300) contribution to each spouse to total maximum six hundred dollars ($600).

(F) The MCHCP contributions will be deposited into the subscriber's HSA as follows:

1. The January deposit will be made on the third Monday of the month, or the first working day after the third Monday if the third Monday is a holiday;

2. The April deposit will be made on the first Monday in April; and

3. Other deposits will be made on the first Monday of the month in which coverage is effective, or the first working day after the first Monday of the month coverage is effective if the first Monday is a state holiday.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

PURPOSE: This amendment revises the medical plan benefits for transition of care, allergy testing and immunotherapy, bariatric surgery, bone growth stimulators, cardiac rehabilitation, chelation therapy, chiropractic services, cochlear implant, dental care, emergency room services, genetic counseling, hearing aids, hospice care and palliative services, hospital, injections, maternity coverage, nutrition therapy, orthognathic or jaw surgery, orthotics, and renumbers as necessary.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

[(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. Benefits eligible for transition of care include:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;

(C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;

(D) Home nursing care;

(E) Radiation therapy;

(F) Dialysis;

(G) Durable medical equipment;

(H) Cancer treatment;

(I) Clinical trials;

(J) Physical, speech, or occupational therapy;

(K) Hospice care;

(L) Bariatric surgery, and follow-up per criteria covered under the plan;

(M) Inpatient hospitalization at the time of the network change;

(N) Mental health services; or

(O) Related follow-up services within three (3) months of an acute injury or surgery.]

(2) Transition of Care. A transition of care option is available for members who seek to continue to remain under the care of an non-network provider who was treating them prior to the provider losing network status. A subscriber and his/her dependents may request to continue receiving care at the network benefit level. If approved, the member will be eligible to continue care with the current non-network provider at the network benefit level for a period of time until it is medically approprate for the member to transfer care to a network provider. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. The following benefits are eligible for transition of care as determined by the claims administrator:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their third trimester of pregnancy;

(C) Radiation therapy;

(D) Dialysis;

(E) Cancer treatment;

(F) Physical, speech, or occupational therapy;

(G) Hospice care;

(H) Inpatient hospitalization at the time of the network change; or

(I) Mental health services.

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250, and HSA Plan.

[(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.]

*[(E)]***(D)** Plan benefits for the PPO 750 Plan, PPO 1250, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms*[. The following tests and treatments are covered:]***;**

[A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or

(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or

(II) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;]

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism;

4. Bariatric surgery*[. Bariatric surgery is covered when all of the following requirements have been met:]***;**

[A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;]

5. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

6. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit*[. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:]*;

[A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;]

7. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

8. Cardiac rehabilitation*[. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:]*;

[A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;]

9. Chelation therapy*[. The administration of FDA-approved chelating agents is covered for any of the following conditions:]*;

[A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;]

10. Chiropractic services*[. Chiropractic]*—manipulation and adjunct therapeutic procedures/modalities *[(e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:]***;**

[A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed homecare program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);]

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant *[device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:]* **and auditory brainstem implant;**

[A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;]

13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. Treatment must be initiated within sixty (60) days of accident; and

(II) Restorative services limited to dental implants when needed as a result of *[cancerous or non-cancerous]* tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. Diabetes Self-Management Education;

15. Dialysis is covered when received through a network provider;

16. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

17. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit*[. Hospital and ancillary charges are paid as a network benefit]*;

18. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement within one (1) year following cataract surgery;

19. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

20. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing*[.]*;

[A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azoopermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test,

maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;]

21. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

22. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

23. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

24. Hearing aids (per ear). Hearing aids *[are]* covered **once every two (2) years** for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

[A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years.] If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

*[(I)]***A.** Conventional: one thousand dollars ($1,000).

*[(II)]***B.** Programmable: two thousand dollars ($2,000).

*[(III)]***C.** Digital: two thousand five hundred dollars ($2,500).

*[(IV)]***D.** Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

25. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

26. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

27. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill *[and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.]***;**

[A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;]

28. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services *[are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:]* **; and**

[(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and]

(V) Outpatient mental health services *[are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:]* **;**

[(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;]

29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

30. Injections. See preventive services for coverage of vaccinations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit*[.]* **;**

[A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;
(II) Crohn's disease;
(III) Ulcerative colitis;
(IV) Inflammatory bowel disease;
(V) Intestinal malabsorption;
(VI) Fish tapeworm anemia;
(VII) Vitamin B12 deficiency;
(VIII) Other vitamin B12 deficiency anemia;
(IX) Macrocytic anemia;
(X) Other specified megaloblastic anemias;
(XI) Megaloblastic anemia;
(XII) Malnutrition of alcoholism;
(XIII) Thrombocytopenia, unspecified;
(XIV) Dementia in conditions classified elsewhere;
(XV) Polyneuropathy in diseases classified elsewhere;
(XVI) Alcoholic polyneuropathy;
(XVII) Regional enteritis of small intestine;
(XVIII) Postgastric surgery syndromes;
(XIX) Other prophylactic chemo-therapy;
(XX) Intestinal bypass or anastomosis status;
(XXI) Acquired absence of stomach;
(XXII) Pancreatic insufficiency; and
(XXIII) Ideopathic progressive polyneuropathy;]

31. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

32. Maternity coverage. Prenatal and postnatal care is covered.

Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to *[the]* **applicable copayments,** deductible**,** and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

33. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

34. Nutrition therapy*[.]***;**

[A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;]

35. Office visit. Member encounter with a provider for health care, mental health, or substance use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

36. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

37. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. *[Cancerous or non-cancerous t]***T**umors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical *[or physiological]* abnormality *[when one (1) of the following criteria is met:]***;**

[(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibularfossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;]

38. Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with agoniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered *[for members who meet the following criteria:]***.**

[(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.]

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes

inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

39. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. Online weight management program offered through the plan's exclusive provider arrangement;

40. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

41. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

42. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

43. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

44. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

45. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

46. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

47. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.061 Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment revises the following benefits not payable by the plan: alternative therapies, assistant surgeon services, birthing center, home births, nocturnal enuresis alarm, therapy, vaccinations requested by a third party, and renumbers as necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-2.055 or 22 CSR 10-2.090.

(C) Alternative therapies—that are outside conventional medicine *[including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback]* **as determined by the claims administrator**.

[(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.]

*[(F)]***(E)** Athletic enhancement services and sports performance training.

*[(G)]***(F)** Autopsy.

[(H) Birthing center.]

*[(I)]***(G)** Blood donor expenses.

*[(J)]***(H)** Blood pressure cuffs/monitors.

*[(K)]***(I)** Care received without charge.

*[(L)]***(J)** Charges exceeding the vendor contracted rate or benefit limit.

*[(M)]***(K)** Charges resulting from the failure to appropriately cancel a scheduled appointment.

*[(N)]***(L)** Childbirth classes.

*[(O)]***(M)** Comfort and convenience items.

*[(P)]***(N)** Cosmetic procedures.

*[(Q)]***(O)** Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

*[(R)]***(P)** Dental care, including oral surgery.

*[(S)]***(Q)** Devices or supplies bundled as part of a service are not

separately covered.

*[(T)]***(R)** Dialysis received through a non-network provider.

*[(U)]***(S)** Educational or psychological testing unless part of a treatment program for covered services.

*[(V)]***(T)** Examinations requested by a third party.

*[(W)]***(U)** Exercise equipment.

*[(X)]***(V)** Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

*[(Y)]***(W)** Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

*[(Z)]***(X)** Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

*[(AA)]***(Y)** Health and athletic club membership—including costs of enrollment.

*[(BB)]***(Z)** Hearing aid replacement batteries.

[(CC) Home births.]

*[(DD)]***(AA)** Infertility treatment beyond the covered services to diagnose the condition.

*[(EE)]***(BB)** Infusions received through a non-network provider.

*[(FF)]***(CC)** Level of care, greater than is needed for the treatment of the illness or injury.

*[(GG)]***(DD)** Long-term care.

*[(HH)]***(EE)** Maxillofacial surgery.

*[(II)]***(FF)** Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

*[(JJ)]***(GG)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

*[(KK)]***(HH)** Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

*[(LL)]***(II)** Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

[(MM) Nocturnal enuresis alarm.]

*[(NN)]***(JJ)** Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

*[(OO)]***(KK)** Non-medically necessary services.

*[(PP)]***(LL)** Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

*[(QQ)]***(MM)** Non-reusable disposable supplies.

*[(RR)]***(NN)** Online weight management programs.

*[(SS)]***(OO)** Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

*[(TT)]***(PP)** Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, nonsedating antihistamines, unless otherwise covered as a preventive service.

*[(UU)]***(QQ)** Physical and recreational fitness.

*[(VV)]***(RR)** Private-duty nursing.

*[(WW)]***(SS)** Routine foot care without the presence of systemic disease that affects lower extremities.

*[(XX)]***(TT)** Services obtained at a government facility if care is provided without charge.

*[(YY)]***(UU)** Sex therapy.

*[(ZZ)]***(VV)** Surrogacy—pregnancy coverage is limited to plan member.

*[(AAA)]***(WW)** Telehealth site origination fees or costs for the provision of telehealth services are not covered.

[(BBB) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or

enhance job, school, or recreational performance; and

l. Long-term rehabilitative services when significant therapeutic improvement is not expected.]

*[(CCC)]***(XX)** Travel expenses.

[(DDD) Vaccinations requested by third party.]

*[(EEE)]***(YY)** Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment revises the order of benefit determination rules and renumbers as necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(3) Order of Benefit Determination Rules.

(B) Rules. MCHCP determines its order of benefits *[using the first of the following rules which applies]* **as follows**:

[1. Active/inactive employee. The benefits of the plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of the plan which covers that person as a laid off or retired employee (or as that employee's dependent);

2. Nondependent/dependent. The benefits of the plan which covers the person as an employer or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent;]

1. Non-Dependent/Dependent:

A. The plan which covers the member as an employee or subscriber is primary.

B. The plan which covers the member as dependent is secondary.

2. Active/layoff. The plan that covers the member or dependent through the member's active employment is primary to a plan that covers the member or dependent through the member's status as a laid off employee.

3. Retiree. The plan that covers the member or dependent through the member's active employment is primary to a plan that covers the member or dependent through the member's status as a retiree.

*[3.]***4.** Medicare.

A. If a member is an active employee and has Medicare, MCHCP is the primary plan for the active employee and his/her dependents. Medicare is the secondary plan except for members with end stage renal disease (ESRD) as defined in subparagraph (3)(B)*[3.]***4.**D.

B. If a member is a retiree and has Medicare, Medicare is the primary plan for the retiree and his/her Medicare-eligible dependents. MCHCP is the secondary plan.

C. If a terminated vested employee with Medicare maintains coverage through one (1) of the MCHCP plans, Medicare is the primary plan and MCHCP is secondary.

D. If a member or his/her dependents are eligible for Medicare solely because of ESRD, the member's MCHCP plan is primary to Medicare during the first thirty (30) months of Medicare eligibility for home peritoneal dialysis or home hemodialysis and thirty-three (33) months for in-center dialysis. After the thirty (30) or thirty-three (33) months, Medicare becomes primary, and claims are submitted first to Medicare, then to MCHCP for secondary coverage. The member is responsible for notifying MCHCP of his/her Medicare status.

E. If a member is on long-term disability through the Missouri State Employees' Retirement System or the Public School Retirement System and is eligible for Medicare, Medicare is the primary plan and MCHCP plan is secondary;

*[4.]***5.** Dependent child/parents not separated or divorced. When MCHCP and another plan cover the same child as a dependent of different *[persons, called]* parents—

A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

B. If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time;

*[5.]***6.** Dependent child/separated, divorced, or never married. If two (2) or more plans cover a person as a dependent child of divorced, separated, or never married parents, benefits for the child are determined in this order—

A. First, the plan of the parent with custody of the child;

B. Then, the plan of the spouse of the parent with the custody

of the child;

C. Then, the plan of the parent not having custody of the child; and

D. Finally, the plan of the spouse of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;

*[6.]***7.** Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (3)(B)*[4.]***5.**

*[7.]***8.** Dependent child/parents both parents covered by MCHCP. If both parents are covered by MCHCP and both parents cover the child as a dependent, MCHCP will not coordinate benefits with itself;

*[8.]***9.** *[The plan that covers the member as a spouse is primary over the plan that covers the member as a dependent child]* **When an adult dependent is covered by both spouse and parent, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term**; and

*[9.]***10.** Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term.

*AUTHORITY: sections 103.059[, RSMo 2000,] and [section] 103.089, RSMo [Supp. 2013] **2016**. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (1), (3), and (5).

PURPOSE: This amendment revises the claim submission and initial benefit determinations time frames, updates the name and appeal contact information for the third party administrator.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(1) Claims Submissions and Initial Benefit Determinations PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than *[fifteen (15) days]* **twenty (20) business days** from the date the vendor receives the claim. The vendor may extend the time period up to an additional *[fifteen (15)]* **twenty (20)** days if, for reasons beyond the vendor's control, the decision cannot be made within the first *[fifteen (15)]* **twenty (20)** days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor *[as soon as possible thereafter]* **within three (3) business days**.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than *[thirty (30) days]* **(20) business days** after the vendor receives the claim. If, because of reasons

beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-) day]* **twenty- (20-) day** period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15) days]* **thirty (30) days** after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously-approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously-approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(3) Appeal Process for Medical and Pharmacy Determinations for PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply:

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage after an individual has been covered under the plan;

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination;

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative;

4. External review. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by *[UMR, Aetna]* **Anthem**, and Express Scripts, Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time);

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law;

6. Final external review decision. A final external review decision means a determination rendered under the external review process at the conclusion of an external review; and

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect; or

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-2.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be *[responded to in writing to the member]* **decided** within thirty (30) **business** days *[for post-service claims and fifteen (15) days for pre-service claims]* from the date the vendor received the first level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)]* **twenty- (20-)** day period, explain the reason for the delay, and request any additional information. If more information is

requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15)]* **thirty (30)** days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first. **Written confirmation of the decision will be sent by the vendor within fifteen (15) business days.**

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service**, first and second level post-service,** and concurrent claim appeals must be submitted in writing to—

[UMR Appeals
PO Box 400046
San Antonio, TX 78229
or by fax to (888) 615-6584]
Anthem Blue Cross and Blue Shield
Attn: Grievance Department
PO Box 105568
Atlanta, Georgia 30348-5568
or by fax to (800) 859-3046

[(b) First and second level post-service appeals must be sent in writing to—
UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546
or by fax to (877) 291-3248]

*[(c)]***(b)** Expedited *[pre-service]* appeals *[must]* **may** be *[communicated]* **submitted** by calling *[(800) 808-4424, ext. 15227]* **(877) 333-7488** or by submitting a written fax to *[(888) 615-6584, Attention: Appeals Unit]****(800) 368-3238***.

[(VI) For members with medical coverage through Aetna—

(a) First and second level appeals must be submitted in writing to—

Aetna
Appeals Resolution Team
PO Box 14463
Lexington, KY 40512
or by fax to (859) 425-3379

(b) Expedited appeals must be communicated by calling (800) 245-0618 or by submitting a written fax to (859) 425-3379, Attention: Appeals Resolution Team.]

C. The internal review process for adverse benefit determinations relating to pharmacy and the Pharmacy Lock-In Program consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals. Pharmacy appeals and Pharmacy Lock-In Program appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, and any applicable reason(s) relevant to the appeal including: the reason(s) the member believes the claim should be paid, the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63116-6588
or by fax to (877) 852-4070

(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—

Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121

(IV) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

(V) The Pharmacy Benefit Manager will respond to Pharmacy Lock-In Program appeals in writing to the member within thirty (30) days from the date the Pharmacy Benefit Manager received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
http://www.externalappeal.com/

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines. Decisions concerning eligibility for Medicare primary members may not be able to be granted pursuant to these guidelines if the decision is contrary to the rules controlling eligibility for Medicare Advantage plan as put forth by Centers for Medicare and Medicaid. Valid proof of eligibility must be included with the appeal if the enrollment request includes addition of dependent(s). Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction:

(J) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier, except that no changes will be considered for HSA Plan elections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan; **and**

(K) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancelation or an appeal of a deadline that is statutorily mandated *[; and]*

[(L) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment].

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment updates the Medicare Part D coverage stage amounts and copayment amounts.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(1) The pharmacy benefit for Medicare primary non-active members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non–Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and Medicaid Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach *[three thousand eight hundred*

twenty dollars ($3,820)] **four thousand twenty dollars ($4,020)**, the member will pay the following copayments:

A. Preferred Formulary Generic Drugs: thirty-one- (31-) day supply has a ten dollar ($10) copayment; sixty- (60-) day supply has a twenty dollar ($20) copayment; ninety- (90-) day supply at retail has a thirty dollar ($30) copayment; and a ninety- (90-) day supply through home delivery has a twenty-five dollar ($25) copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a forty dollar ($40) copayment; sixty- (60-) day supply has an eighty ($80) dollar copayment; ninety- (90-) day supply at retail has a one hundred twenty ($120) dollar copayment; and a ninety- (90-) day supply through home delivery has a one hundred ($100) dollar copayment; and

C. Non-preferred Formulary Drugs and approved excluded drugs: thirty-one- (31-) day supply has a one hundred dollar ($100) copayment; sixty- (60-) day supply has a two hundred dollar ($200) copayment; ninety- (90-) day supply at retail has a three hundred dollar ($300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar ($250) copayment;

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[three thousand eight hundred twenty dollars ($3,820)]* **four thousand twenty dollars ($4,020)** and remain below *[five thousand one hundred dollars ($5,100)]* **six thousand three hundred fifty dollars ($6,350)**, the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach *[five thousand one hundred dollars ($5,100)]* **six thousand three hundred fifty dollars ($6,350)**;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach*[five thousand one hundred dollars ($5,100)]* **six thousand three hundred fifty dollars ($6,350)**, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[three dollar and forty cent ($3.40)]* **three dollar and sixty cent ($3.60)** copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or an *[eight dollar and fifty cent ($8.50)]* **eight dollar and ninety-five cent ($8.95)** copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage; and

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment adds coinsurance dollar limits for the Health Savings Account (HSA) Plan, revises services covered at one hundred percent (100%), makes a technical correction to (1)(B)1.2.B., and renumbers as necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider to non-Medicare primary members.

(A) PPO 750 Plan and PPO 1250 Plan.

1. Network:

A. Preferred formulary generic drug copayment: Ten Dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and thirty dollars ($30) for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Preferred formulary brand drug copayment: Forty dollars ($40) for up to a thirty-one- (31-) day supply; eighty dollars ($80) for up to a sixty- (60-) day supply; and one hundred twenty dollars ($120) for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Specialty drug copayment: Seventy-five dollars ($75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

E. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A

member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply and charged a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped and the member will be charged the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: Ten dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and twenty-five dollars ($25) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: Forty dollars ($40) for up to a thirty-one- (31-) day supply; eighty dollars ($80) for up to a sixty- (60-) day supply; and one hundred dollars ($100) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary;

(d) Specialty drug copayment: Seventy-five dollars ($75) for up to a thirty-one- (31-) day supply; one hundred fifty ($150) for up to sixty (60-) day supply; and two hundred twenty-five ($225) for up to ninety- (90-) day supply for a specialty drug on the formulary;

G. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

H. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

I. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied;

J. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

K. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum;

L. Preferred select brand drugs, as determined by the PBM: Ten dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and twenty-five dollars ($25) for up to a ninety- (90-) day supply; and

M. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Vaccine recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

[(II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;]

*[(III)]***(II)** Prescribed preferred diabetic test strips and lancets; and

*[(IV)]***(III)** One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Network individual—four thousand one hundred fifty dollars ($4,150).

D. Network family—eight thousand three hundred dollars ($8,300).

E. Non-network—no maximum.

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-2.053.

1. Network:

A. Preferred formulary generic drug: Ten percent (10%) coinsurance **up to fifty dollars ($50) per thirty-one- (31-) day supply** after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: Twenty percent (20%) coinsurance **up to one hundred dollars ($100) per thirty-one- (31-) day supply** after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met**, not to exceed**:

(I) Twenty-five dollars ($25) per thirty-one- (31-) day supply for generic drugs;

(II) Fifty dollars ($50) per thirty-one- (31-) day supply for preferred formulary brand drug; and

(III) One hundred dollars ($100) per thirty-one- (31-) day supply for non-preferred formulary drug;

E. Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment;

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. *[The following are also covered at one hundred percent (100%) when filled at a network pharmacy:]*

*[(I)]***G.** Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention **are covered at one hundred percent (100%) when filled at a network pharmacy**; and

[(II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;]

*[G.]***H**. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer;

*[H.]***I.** If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.110 General Foster Parent Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (3), (5), and (14).

PURPOSE: This amendment revises default enrollment procedures, clarifies disabled dependent eligibility, reporting of other health coverage, and renumbers as necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(3) Enrollment Procedures.

(C) An eligible foster parent may elect or change coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

1. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the eligible foster parent's responsibility to notify MCHCP of the life event;

A. If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

2. Employer-sponsored group coverage loss. An eligible foster parent or his/her spouse/child(ren) may enroll within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances:

A. Employer-sponsored medical, dental, or vision plan terminates;

B. Eligibility for employer-sponsored coverage ends;

C. Employer contributions toward the premiums end; or

D. Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

3. If an eligible foster parent or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

4. If an eligible foster parent or eligible foster parent's spouse receives a court order stating s/he is responsible for covering a child, the eligible foster parent may enroll the child in an MCHCP plan within sixty (60) days of the court order; or

5. Default Enrollment

A. If an eligible foster parent is enrolled in the PPO *[300 or]* **750,** PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled **in the same plan** at the same level of coverage *[in the PPO 1250 Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year]*; or

[B. If an eligible foster parent is enrolled in the Health Savings Account (HSA) Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the HSA Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year;]

*[C.]***B.** If an eligible foster parent is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year; or

6. If an eligible foster parent submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the foster parent of such by mail, phone, or secure message. The foster parent must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date MCHCP notifies the foster parent, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(E) Disabled Dependent.

1. A**n** *[newly]* eligible foster parent may enroll his/her permanently disabled child **when first eligible** or an enrolled permanently disabled dependent turning age twenty-six (26) years, may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the end of the month of the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of *[a new foster parent and his/her]* **the** permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled child's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(14) Members are required to disclose to the claims administrator whether they have other health coverage and, if so, information about the coverage. *[A member may submit other coverage information to the claims administrator by phone, fax, mail, or online. Dependent claims will be denied until the information is received.]* Once the information is received, claims will be reprocessed subject to all applicable rules.

AUTHORITY: sections 103.059 and 103.078, RSMo 2016. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (5) and (13).

PURPOSE: This amendment clarifies disabled dependent eligibility and reporting of other health coverage.

EMERGENCY STATEMENT: This emergency amendment must be in

place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(5) Proof of Eligibility.

(F) Disabled dependent.

1. A**n** *[new]* employee may enroll his/her permanently disabled child **when first eligible** or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the end of the month of the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of *[a new employee and his/her]* **the** permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(13) Members are required to disclose to the claims administrator whether or whether not they have other health coverage and, if so, information about the coverage. *[A member may submit this information to the claims administrator by phone, fax, mail, or online. Dependent claims will be denied if the disclosure is not made.]* Once the information is received, claims will be reprocessed subject to all applicable rules.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of Sate Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RESCISSION

22 CSR 10-3.045 Plan Utilization Review Policy. This rule established the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes due to a new third party administrator.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2020 in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rescission complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500)

in the aggregate.

PRIVATE COST: This emergency rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2020 in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization—The claims administrator must authorize some services in advance. Preauthorization is to determine if the procedure or treatment is medically necessary. The claims administrator will determine what procedures or treatments are subject to preauthorization. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, or who are enrolled in the Medicare Advantage Plan are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. A list of medical services for which preauthorization is required may be obtained at any time from the claims administrator.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization requests will be made within thirty-six (36) hours, which will include one (1) business day of the receipt of the request. If the information necessary to make a benefit determination is not received, the claims administrator will notify the member and provider of any necessary extension. The provider will be given forty-five (45) calendar days from receipt of the extension notice to respond with additional information. Once the information is received or the forty-five (45) days have elapsed, a determination will be made within thirty-six (36) hours which will include one (1) business day.

B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than one (1) business day of the receipt of all necessary information;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision;

(C) Retrospective Review—Reviews to determine coverage after services have been provided to a member. The retrospective review is not limited to an evaluation of medical necessity, reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment. The claim administrator shall have the authority to correct payment errors when identified under retrospective review;

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment; and

(E) Case Management—A voluntary process to assess, coordinate, and evaluate options and services of members with catastrophic and complex illnesses. A case manager will help members understand what to expect during the course of treatment, help establish collaborative goals, complete assessments to determine needs, interface with providers, and negotiate care. Members are identified for case management through claim information, length of hospital stay, or by referral. The case manager will dismiss the member from case management once the case manager determines that objectives have been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed rescission and rule covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (3), (13), (14), (18), and adding section (9).

PURPOSE: This amendment revises the Health Savings Account (HSA) Plan individual family member out-of-pocket maximum, adds one hundred percent (100%) coverage after deductible is met for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, services performed in another country, and renumbers as necessary.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—four thousand nine hundred fifty dollars ($4,950);

2. Network out-of-pocket maximum for family—nine thousand nine hundred dollars ($9,900). Any individual family member need only incur a maximum of *[seven thousand nine hundred dollars ($7,900)]* **eight thousand one hundred fifty dollars ($8,150)** before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual—nine thousand nine hundred dollars ($9,900); and

4. Non-network out-of-pocket maximum for family—nineteen thousand eight hundred dollars ($19,800).

(9) Sterilization procedure for men is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

*[(9)]***(10)** Newborn's claims will be subject to deductible and coinsurance.

*[(10)]***(11)** Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

*[(11)]***(12)** Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

*[(12)]***(13)** Maximum plan payment—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claim administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

*[(13)]***(14)** Any claim must be initially submitted within twelve (12) months following the date of service**, unless other specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

*[(14)]***(15)** For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

*[(15)]***(16)** A subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (16) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare (unless Medicare is secondary coverage to MCHCP);

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-purpose health FSA, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

*[(16)]***(17)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;
(B) Accident insurance;
(C) Disability insurance;
(D) Dental insurance;
(E) Vision insurance; or
(F) Long-term care insurance.

*[(17)]***(18)** Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

PURPOSE: This amendment revises the medical plan benefits for transition of care, allergy testing and immunotherapy, bariatric surgery, bone growth stimulators, cardiac rehabilitation, chelation therapy, chiropractic services, cochlear implant, dental care, emergency room services, genetic counseling, hearing aids, hospice care and palliative services, hospital, injections, maternity coverage, nutrition therapy, orthognathic or jaw surgery, orthotics, and renumbers as necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

[(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. Benefits eligible for transition of care include:

(A) Upcoming surgery or prospective transplant;
(B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;
(C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;
(D) Home nursing care;
(E) Radiation therapy;
(F) Dialysis;
(G) Durable medical equipment;
(H) Cancer treatment;
(I) Clinical trials;
(J) Physical, speech, or occupational therapy;
(K) Hospice care;
(L) Bariatric surgery, and follow-up per criteria covered under the plan;
(M) Inpatient hospitalization at the time of the network change;
(N) Mental health services; or
(O) Related follow-up services within three (3) months of an acute injury or surgery.]

(2) Transition of Care. A transition of care option is available for members who seek to continue to remain under the care of an non-network provider who was treating them prior to the provider losing network status. A subscriber and his/her dependents may

request to continue receiving care at the network benefit level. If approved, the member will be eligible to continue care with the current non-network provider at the network benefit level for a period of time until it is medically appropriate for the member to transfer care to a network provider. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. The following benefits are eligible for transition of care as determined by the claims administrator:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their third trimester of pregnancy;

(C) Radiation therapy;

(D) Dialysis;

(E) Cancer treatment;

(F) Physical, speech, or occupational therapy;

(G) Hospice care;

(H) Inpatient hospitalization at the time of the network change; or

(I) Mental health services.

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250, and HSA Plan.

[(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.]

*[(E)]***(D)** Plan benefits for the PPO 750 Plan, PPO 1250, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms*[. The following tests and treatments are covered:]***;**

[A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or

(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or

(III) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;]

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism;

4. Bariatric surgery*[. Bariatric surgery is covered when all of the following requirements have been met:]***;**

[A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;]

5. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

6. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit*[. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:]***;**

[A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;]

7. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

8. Cardiac rehabilitation*[. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of*

*the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:]***;**

[A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;]

9. Chelation therapy*[. The administration of FDA-approved chelating agents is covered for any of the following conditions:]***;**

[A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;]

10. Chiropractic services*[. Chiropractic]*—manipulation and adjunct therapeutic procedures/modalities *[(e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:]***;**

[A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed homecare program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);]

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant *[device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:]* **and auditory brainstem implant;**

[A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;]

13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. Treatment must be initiated within sixty (60) days of accident; and

(II) Restorative services limited to dental implants when needed as a result of *[cancerous or non-cancerous]* tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. Diabetes Self-Management Education;

15. Dialysis is covered when received through a network provider;

16. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

17. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit*[. Hospital and ancillary charges are paid as a network benefit]*;

18. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement within one (1) year following cataract surgery;

19. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

20. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing*[.]***;**

[A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azoopermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;]

21. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

22. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

23. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

24. Hearing aids (per ear). Hearing aids *[are]* covered **once every two (2) years** for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

[A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years.] If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

*[(I)]***A.** Conventional: one thousand dollars ($1,000).

*[(II)]***B.** Programmable: two thousand dollars ($2,000).

*[(III)]***C.** Digital: two thousand five hundred dollars ($2,500).

*[(IV)]***D.** Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

25. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

26. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

27. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill *[and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.]***;**

[A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;]

28. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services *[are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:]***; and**

[(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and]

(V) Outpatient mental health services *[are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:]***;**

[(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;]

29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

30. Injections. See preventive services for coverage of vaccinations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit*[.]***;**

[A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;
(III) Ulcerative colitis;
(IV) Inflammatory bowel disease;
(V) Intestinal malabsorption;
(VI) Fish tapeworm anemia;
(VII) Vitamin B12 deficiency;
(VIII) Other vitamin B12 deficiency anemia;
(IX) Macrocytic anemia;
(X) Other specified megaloblastic anemias;
(XI) Megaloblastic anemia;
(XII) Malnutrition of alcoholism;
(XIII) Thrombocytopenia, unspecified;
(XIV) Dementia in conditions classified elsewhere;
(XV) Polyneuropathy in diseases classified elsewhere;
(XVI) Alcoholic polyneuropathy;
(XVII) Regional enteritis of small intestine;
(XVIII) Postgastric surgery syndromes;
(XIX) Other prophylactic chemo-therapy;
(XX) Intestinal bypass or anastomosis status;
(XXI) Acquired absence of stomach;
(XXII) Pancreatic insufficiency; and
(XXIII) Ideopathic progressive polyneuropathy;]

31. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

32. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to *[the]* **applicable copayments,** deductible**,** and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

33. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

34. Nutrition therapy*[.]***;**

[A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;]

35. Office visit. Member encounter with a provider for health care, mental health, or substance use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

36. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

37. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. *[Cancerous or non-cancerous t]***T**umors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical *[or physiological]* abnormality *[when one (1) of the following criteria is met:]***;**

[(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibularfossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;]

38. Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with agoniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered *[for members who meet the following criteria:]***.**

[(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.]

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or

related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

39. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. Online weight management program offered through the plan's exclusive provider arrangement;

40. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

41. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

42. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

43. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

44. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, postoperative vocal cord surgery);

45. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

46. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

47. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.058 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (5), (11), (12), and (14).

PURPOSE: This amendment adds one hundred percent (100%) coverage for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, and services performed in another country for the PPO 750 Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; *[and]*

(D) Four (4) Diabetes Self-Management Education visits*[.]***; and**

(E) Sterilization procedure for men.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claim administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service, **unless other specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-*[2.055]* **3.057**. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 30, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.059 PPO 1250 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (5), (11), (12), and (14).

PURPOSE: This amendment adds one hundred percent (100%) coverage for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, and services performed in another country for the PPO 1250 Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; *[and]*

(D) Four (4) Diabetes Self-Management Education visits*[.]***; and**

(E) Sterilization procedure for men.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claim administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service**, unless other specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed

Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 30, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.061 Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

PURPOSE: This amendment revises the following benefits not payable by the plan: alternative therapies, assistant surgeon services, birthing center, home births, nocturnal enuresis alarm, therapy, vaccinations requested by a third party, and renumbers as necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-3.057 or 22 CSR 10-3.090.

(C) Alternative therapies—that are outside conventional medicine *[including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback]* **as determined by the claims administrator**.

[(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.]

*[(F)]***(E)**Athletic enhancement services and sports performance training.

*[(G)]***(F)** Autopsy.

[(H) Birthing center.]

*[(I)]***(G)** Blood donor expenses.

*[(J)]***(H)** Blood pressure cuffs/monitors.

*[(K)]***(I)** Care received without charge.

*[(L)]***(J)** Charges exceeding the vendor contracted rate or benefit limit.

*[(M)]***(K)** Charges resulting from the failure to appropriately cancel a scheduled appointment.

*[(N)]***(L)** Childbirth classes.

*[(O)]***(M)** Comfort and convenience items.

*[(P)]***(N)** Cosmetic procedures.

*[(Q)]***(O)** Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

*[(R)]***(P)** Dental care, including oral surgery.

*[(S)]***(Q)** Devices or supplies bundled as part of a service are not separately covered.

*[(T)]***(R)** Dialysis received through a non-network provider.

*[(U)]***(S)** Educational or psychological testing unless part of a treatment program for covered services.

*[(V)]***(T)** Examinations requested by a third party.

*[(W)]***(U)** Exercise equipment.

*[(X)]***(V)** Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

*[(Y)]***(W)** Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

*[(Z)]***(X)** Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

*[(AA)]***(Y)** Health and athletic club membership—including costs of enrollment.

*[(BB)]***(Z)** Hearing aid replacement batteries.

[(CC) Home births.

*(DD)]***(AA)** Infertility treatment beyond the covered services to diagnose the condition.

*[(EE)]***(BB)** Infusions received through a non-network provider.

*[(FF)]***(CC)** Level of care, greater than is needed for the treatment of the illness or injury.

*[(GG)]***(DD)** Long-term care.

*[(HH)]***(EE)** Maxillofacial surgery.

*[(II)]***(FF)** Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

*[(JJ)]***(GG)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

*[(KK)]***(HH)** Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

*[(LL)]***(II)** Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

[(MM) Nocturnal enuresis alarm.]

*[(NN)]***(JJ)** Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

*[(OO)]***(KK)** Non-medically necessary services.

*[(PP)]***(LL)** Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

*[(QQ)]***(MM)** Non-reusable disposable supplies.

*[(RR)]***(NN)** Online weight management programs.

*[(SS)]***(OO)** Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

*[(TT)]***(PP)** Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, nonsedating antihistamines, unless otherwise covered as a preventive service.

*[(UU)]***(QQ)** Physical and recreational fitness.

*[(VV)]***(RR)** Private-duty nursing.

*[(WW)]***(SS)** Routine foot care without the presence of systemic disease that affects lower extremities.

*[(XX)]***(TT)** Services obtained at a government facility if care is provided without charge.

*[(YY)]***(UU)** Sex therapy.

*[(ZZ)]***(VV)** Surrogacy—pregnancy coverage is limited to plan member.

*[(AAA)]***(WW)** Telehealth site origination fees or costs for the provision of telehealth services are not covered.

[(BBB) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.]

*[(CCC)]***(XX)** Travel expenses.

[(DDD) Vaccinations requested by third party.]

*[(EEE)]***(YY)** Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment revises the order of benefit determination rules and renumbers as necessary.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(3) Order of Benefit Determination Rules.

(B) Rules. MCHCP determines its order of benefits *[using the first of the following rules which applies]* **as follows**:

[1. Active/inactive employee. The benefits of the plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of the plan which covers that person as a laid off or retired employee (or as that employee's dependent);

2. Nondependent/dependent. The benefits of the plan which covers the person as an employer or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent;]

1. Non-Dependent/Dependent:

A. The plan which covers the member as an employee or subscriber is primary.

B. The plan which covers the member as dependent is secondary.

2. Active/layoff. The plan that covers the member or dependent through the member's active employment is primary to a plan that covers the member or dependent through the member's status as a laid off employee.

3. Retiree. The plan that covers the member or dependent through the member's active employment is primary to a plan that covers the member or dependent through the member's status as a retiree.

*[3.]***4.** Medicare.

A. If a member is an active employee and has Medicare, MCHCP is the primary plan for the active employee and his/her dependents. Medicare is the secondary plan except for members with end stage renal disease (ESRD) as defined in subparagraph (3)(B)*[3.]***4.**C.

B. If a member is a retiree and has Medicare, Medicare is the primary plan for the retiree and his/her Medicare-eligible dependents. MCHCP is the secondary plan.

C. If a member or his/her dependents are eligible for Medicare solely because of ESRD, the member's MCHCP plan is primary to Medicare during the first thirty (30) months of Medicare eligibility for home peritoneal dialysis or home hemodialysis and thirty-three (33) months for in-center dialysis. After the thirty (30) or thirty-three (33) months, Medicare becomes primary, and claims are submitted first to Medicare, then to MCHCP for secondary coverage. The member is responsible for notifying MCHCP of his/her Medicare status;

*[4.]***5.** Dependent child/parents not separated or divorced. When MCHCP and another plan cover the same child as a dependent of different *[persons, called]* parents—

A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

B. If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time;

*[5.]***6.** Dependent child/separated or divorced, or never married. If two (2) or more plans cover a person as a dependent child of divorced, separated, or never married parents, benefits for the child are determined in this order—

A. First, the plan of the parent with custody of the child;

B. Then, the plan of the spouse of the parent with the custody of the child;

C. Then, the plan of the parent not having custody of the child; and

D. Finally, the plan of the spouse of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;

*[6.]***7.** Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (3)(B)*[4.]***5.**;

*[7.]***8.** Dependent child /parents both parents covered by MCHCP. If both parents are covered by MCHCP and both parents cover the child as a dependent, MCHCP will not coordinate benefits with itself;

*[8.]***9.** *[The plan that covers the member as a spouse is primary over the plan that covers the member as a dependent child]* **When an adult dependent is covered by both spouse and parent, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term**; and

*[9.]***10.** Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term.

*AUTHORITY: sections 103.059 and 103.089, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500)

in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (1), (3), and (5).

PURPOSE: This amendment revises the claim submission and initial benefit determinations time frames, updates the name and appeal contact information for the third party administrator.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(1) Claims Submissions and Initial Benefit Determinations.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than *[fifteen (15) days]* **twenty (20) business days** from the date the vendor receives the claim. The vendor may extend the time period up to an additional *[fifteen (15)]* **twenty (20)** days if, for reasons beyond the vendor's control, the decision cannot be made within the first *[fifteen (15)]* **twenty (20)** days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor *[as soon as possible thereafter]* **within three (3) business days**.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than *[thirty (30) days]* **(20) business days** after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-) day]* **twenty (20-) day** period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15) days]* **thirty (30) days** after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously approved course of treatment in sufficient time to allow the member, or the member's provider, to appeal and obtain a determination before the benefit is reduced or terminated.

(3) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply:

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage after an individual has been covered under the plan;

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit

determination;

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative;

4. External review. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by *[UMR, Aetna]* **Anthem**, and Express Scripts, Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time);

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law;

6. Final external review decision. A final external review decision means a determination rendered under the external review process at the conclusion of an external review; and

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect, except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect; or

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review, except as specifically provided in 22 CSR 10-3.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be *[responded to in writing to the member]* **decided** within thirty (30) **business** days *[for post-service claims and fifteen (15) days for pre-service claims]* from the date the vendor received the first level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)]* **twenty- (20-)** day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15)]* **thirty (30)** days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first. **Written confirmation of the decision will be sent by the vendor within fifteen (15) business days.**

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service**, first and second level post-service,** and concurrent claim appeals must be submitted in writing to—

Anthem Blue Cross and Blue Shield
Attn: Grievance Department
PO Box 105568
Atlanta, Georgia 30348-5568
or by fax to (800) 859-3046

[(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546
or by fax to (877) 291-3248]

*[(c)]***(b)** Expedited *[pre-service]* appeals *[must]* **may** be *[communicated]* **submitted** by calling *[(800) 808-4424, ext. 15227] (***877) 333-7488** or by submitting a written fax to *[(888) 615-6584, Attention: Appeals Unit]* **(800) 368-3238**.

C. The internal review process for adverse benefit determinations relating to pharmacy and the Pharmacy Lock-In Program consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals. Pharmacy appeals and Pharmacy Lock-In Program appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, and any applicable reason(s) relevant to the appeal including: the reason(s) the member believes the claim should be paid, the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63116-6588
or by fax to (877) 852-4070

(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—

Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121

(IV) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

(V) The Pharmacy Benefit Manager will respond to Pharmacy Lock-In Program appeals in writing to the member within thirty (30) days from the date the Pharmacy Benefit Manager received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
http://www.externalappeal.com/

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:

(I) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan; **and**

(J) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated*[; and]***.**

[(K) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment.]

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment adds coinsurance dollar limits for the Health Savings Account (HSA) Plan, revises services covered at one hundred percent (I00%), and renumbers as necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2020, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 30, 2019, becomes effective January 1, 2020, and expires June 28, 2020.*

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider.

(A) PPO 750 Plan and PPO 1250 Plan Prescription Drug Coverage.

1. Network.

A. Preferred formulary generic drug copayment: Ten Dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and thirty dollars ($30) for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. Preferred formulary brand drug copayment: Forty dollars ($40) for up to a thirty-one- (31-) day supply; eighty dollars ($80) for up to a sixty- (60-) day supply; and one hundred twenty dollars ($120) for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Specialty drug (as designated as such by the PBM) copayment: Seventy-five dollars ($75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

E. Diabetic drug (as designated as such by the PBM) copayment: Fifty percent (50%) of the applicable network copayment.

F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescription(s) will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: Ten dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and twenty-five dollars ($25) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: Forty dollars ($40) for up to a thirty-one- (31-) day supply; eighty dollars ($80) for up to a sixty- (60-) day supply; and one hundred dollars ($100) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary.

(d) Specialty drug (as designated as such by the PBM) copayment: Seventy-five dollars ($75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

G. Diabetic drug (as designated as such by the PBM) copayment: Fifty percent (50%) of the applicable network copayment.

H. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

I. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied.

J. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

K. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum.

L. Preferred select brand drugs, as determined by the PBM: Ten dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and twenty-five dollars ($25) for up to a ninety- (90-) day supply;

M. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Vaccine recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

[(II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;]

*[(III)]***(II)** Prescribed preferred diabetic test strips and lancets; and

*[(IV)]***(III)** One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Network individual—four thousand one hundred fifty dollars ($4,150).

D. Network family—eight thousand three hundred dollars ($8,300).

E. Non-network—no maximum.

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. Preferred formulary generic drug: Ten percent (10%) coinsurance **up to fifty dollars ($50) per thirty-one- (31-) day supply** after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: Twenty percent (20%) coinsurance **up to one hundred dollars ($100) per thirty-one- (31-) day supply** after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met**, not to exceed**:

(I) Twenty-five dollars ($25) per thirty-one- (31-) day supply for generic drugs;

(II) Fifty dollars ($50) per thirty-one- (31-) day supply for preferred formulary brand drug; and

(III) One hundred dollars ($100) per thirty-one- (31-) day supply for non-preferred formulary drug;

E. Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through network home delivery for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. *[The following are also covered at one hundred percent (100%) when filled at a network pharmacy:]*

*[(I)]***G.** Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention **are covered at one hundred percent (100%) when filled at a network pharmacy**; and

[(II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;]

*[G.]***H**. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer;

*[H.]***I.** If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: Fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo.

Office of the Governor

State of Missouri

Governor's Proclamation

WHEREAS, Article IV, Section 27, authorizes the Governor to control the rate at which any appropriation is expended by allotment and, further, authorizes the Governor to reduce the expenditures of the state or any of its agencies below their appropriations whenever the actual revenues are less than the revenue estimates upon which the appropriations were based; and

WHEREAS, in addition to the power to control the rate of expenditure established in Article IV, Section 27, three percent of each appropriation, with the exception of amounts for personal service to pay salaries fixed by law, shall be set aside pursuant to section 33.290, RSMo, as a reserve fund and not subject to expenditure except with the approval of the Governor; and

WHEREAS, Article IV, Section 27.2, provides that the Governor notify the General Assembly "whenever the rate at which any appropriation shall be expended is not equal quarterly allotments, the sum of which shall be equal to the amount of the appropriation"; and

WHEREAS, due to a variety of factors, including the three percent reserve that is legally required by section 33.290, RSMo, the rate at which most appropriations are expended is not in "equal quarterly allotments, the sum of which shall be equal to the amount of the appropriation"; and

WHEREAS, Article IV, Section 27.3, provides that the Governor notify the General Assembly "when the governor reduces one or more items or portions of items of appropriation of money as a result of actual revenues being less than the revenue estimates upon which the appropriations were based."

NOW THEREFORE, I, Michael L. Parson, GOVERNOR OF THE STATE OF MISSOURI, pursuant to Article IV, Section 27, do hereby make the following notification to the One Hundredth General Assembly of the State of Missouri:

I hereby notify the General Assembly, pursuant to Article IV, Section 27.2 of the Missouri Constitution, that through the first quarter of fiscal year 2020, the rate of expenditure for each of the appropriation lines in the fiscal year 2020 budget attached as Exhibit A is not in equal quarterly allotments, the sum of which shall be equal to the amount of the appropriation.

I further notify the General Assembly, pursuant to Article IV, Section 27.3 of the Missouri Constitution, that I have taken no action to permanently reduce one or more items or portions of items of appropriation of money as a result of actual revenues being less than the revenue estimates upon which the appropriations were based in the fiscal year 2020 budget.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, this 28th day of October, 2019.

Michael L. Parson
GOVERNOR

ATTEST:

SECRETARY OF STATE

Exhibit A

#	Agnecy	Budget Appropriation Line
1	OFFICE ADMINISTRATION-OPER	01.010
2	OFFICE ADMINISTRATION-OPER	01.015
3	OFFICE ADMINISTRATION-OPER	01.015
4	OFFICE ADMINISTRATION-OPER	01.020
5	OFFICE ADMINISTRATION-OPER	01.020
6	OFFICE ADMINISTRATION-OPER	01.025
7	OFFICE ADMINISTRATION-OPER	01.025
8	OFFICE ADMINISTRATION-OPER	01.025
9	OFFICE ADMINISTRATION-OPER	01.030
10	OFFICE ADMINISTRATION-OPER	01.035
11	ELEM & SEC EDUCATION-OPER	02.005
12	ELEM & SEC EDUCATION-OPER	02.005
13	ELEM & SEC EDUCATION-OPER	02.005
14	ELEM & SEC EDUCATION-OPER	02.005
15	ELEM & SEC EDUCATION-OPER	02.006
16	ELEM & SEC EDUCATION-OPER	02.006
17	ELEM & SEC EDUCATION-OPER	02.006
18	ELEM & SEC EDUCATION-OPER	02.010
19	ELEM & SEC EDUCATION-OPER	02.010
20	ELEM & SEC EDUCATION-OPER	02.015
21	ELEM & SEC EDUCATION-OPER	02.015
22	ELEM & SEC EDUCATION-OPER	02.015
23	ELEM & SEC EDUCATION-OPER	02.015
24	ELEM & SEC EDUCATION-OPER	02.015
25	ELEM & SEC EDUCATION-OPER	02.015
26	ELEM & SEC EDUCATION-OPER	02.015
27	ELEM & SEC EDUCATION-OPER	02.015
28	ELEM & SEC EDUCATION-OPER	02.015
29	ELEM & SEC EDUCATION-OPER	02.015
30	ELEM & SEC EDUCATION-OPER	02.015
31	ELEM & SEC EDUCATION-OPER	02.015
32	ELEM & SEC EDUCATION-OPER	02.015
33	ELEM & SEC EDUCATION-OPER	02.015
34	ELEM & SEC EDUCATION-OPER	02.015
35	ELEM & SEC EDUCATION-OPER	02.015
36	ELEM & SEC EDUCATION-OPER	02.015
37	ELEM & SEC EDUCATION-OPER	02.020
38	ELEM & SEC EDUCATION-OPER	02.025
39	ELEM & SEC EDUCATION-OPER	02.030
40	ELEM & SEC EDUCATION-OPER	02.035
41	ELEM & SEC EDUCATION-OPER	02.040
42	ELEM & SEC EDUCATION-OPER	02.045
43	ELEM & SEC EDUCATION-OPER	02.050
44	ELEM & SEC EDUCATION-OPER	02.055
45	ELEM & SEC EDUCATION-OPER	02.060
46	ELEM & SEC EDUCATION-OPER	02.065
47	ELEM & SEC EDUCATION-OPER	02.066
48	ELEM & SEC EDUCATION-OPER	02.067
49	ELEM & SEC EDUCATION-OPER	02.070
50	ELEM & SEC EDUCATION-OPER	02.075
51	ELEM & SEC EDUCATION-OPER	02.080
52	ELEM & SEC EDUCATION-OPER	02.080
53	ELEM & SEC EDUCATION-OPER	02.080
54	ELEM & SEC EDUCATION-OPER	02.085
55	ELEM & SEC EDUCATION-OPER	02.090
56	ELEM & SEC EDUCATION-OPER	02.095
57	ELEM & SEC EDUCATION-OPER	02.095
58	ELEM & SEC EDUCATION-OPER	02.095

Exhibit A

#	Agnecy	Budget Appropriation Line
59	ELEM & SEC EDUCATION-OPER	02.095
60	ELEM & SEC EDUCATION-OPER	02.095
61	ELEM & SEC EDUCATION-OPER	02.095
62	ELEM & SEC EDUCATION-OPER	02.095
63	ELEM & SEC EDUCATION-OPER	02.095
64	ELEM & SEC EDUCATION-OPER	02.100
65	ELEM & SEC EDUCATION-OPER	02.100
66	ELEM & SEC EDUCATION-OPER	02.100
67	ELEM & SEC EDUCATION-OPER	02.100
68	ELEM & SEC EDUCATION-OPER	02.100
69	ELEM & SEC EDUCATION-OPER	02.105
70	ELEM & SEC EDUCATION-OPER	02.110
71	ELEM & SEC EDUCATION-OPER	02.110
72	ELEM & SEC EDUCATION-OPER	02.110
73	ELEM & SEC EDUCATION-OPER	02.115
74	ELEM & SEC EDUCATION-OPER	02.120
75	ELEM & SEC EDUCATION-OPER	02.125
76	ELEM & SEC EDUCATION-OPER	02.130
77	ELEM & SEC EDUCATION-OPER	02.135
78	ELEM & SEC EDUCATION-OPER	02.140
79	ELEM & SEC EDUCATION-OPER	02.145
80	ELEM & SEC EDUCATION-OPER	02.150
81	ELEM & SEC EDUCATION-OPER	02.155
82	ELEM & SEC EDUCATION-OPER	02.160
83	ELEM & SEC EDUCATION-OPER	02.165
84	ELEM & SEC EDUCATION-OPER	02.170
85	ELEM & SEC EDUCATION-OPER	02.175
86	ELEM & SEC EDUCATION-OPER	02.180
87	ELEM & SEC EDUCATION-OPER	02.180
88	ELEM & SEC EDUCATION-OPER	02.180
89	ELEM & SEC EDUCATION-OPER	02.185
90	ELEM & SEC EDUCATION-OPER	02.190
91	ELEM & SEC EDUCATION-OPER	02.190
92	ELEM & SEC EDUCATION-OPER	02.190
93	ELEM & SEC EDUCATION-OPER	02.190
94	ELEM & SEC EDUCATION-OPER	02.190
95	ELEM & SEC EDUCATION-OPER	02.195
96	ELEM & SEC EDUCATION-OPER	02.195
97	ELEM & SEC EDUCATION-OPER	02.200
98	ELEM & SEC EDUCATION-OPER	02.205
99	ELEM & SEC EDUCATION-OPER	02.210
100	ELEM & SEC EDUCATION-OPER	02.220
101	ELEM & SEC EDUCATION-OPER	02.220
102	ELEM & SEC EDUCATION-OPER	02.220
103	ELEM & SEC EDUCATION-OPER	02.220
104	ELEM & SEC EDUCATION-OPER	02.230
105	ELEM & SEC EDUCATION-OPER	02.235
106	ELEM & SEC EDUCATION-OPER	02.240
107	ELEM & SEC EDUCATION-OPER	02.245
108	ELEM & SEC EDUCATION-OPER	02.250
109	ELEM & SEC EDUCATION-OPER	02.255
110	ELEM & SEC EDUCATION-OPER	02.260
111	ELEM & SEC EDUCATION-OPER	02.265
112	ELEM & SEC EDUCATION-OPER	02.265
113	ELEM & SEC EDUCATION-OPER	02.265
114	ELEM & SEC EDUCATION-OPER	02.265
115	ELEM & SEC EDUCATION-OPER	02.265
116	ELEM & SEC EDUCATION-OPER	02.265

Exhibit A

#	Agnecy	Budget Appropriation Line
117	ELEM & SEC EDUCATION-OPER	02.270
118	ELEM & SEC EDUCATION-OPER	02.270
119	ELEM & SEC EDUCATION-OPER	02.270
120	ELEM & SEC EDUCATION-OPER	02.270
121	ELEM & SEC EDUCATION-OPER	02.270
122	ELEM & SEC EDUCATION-OPER	02.270
123	ELEM & SEC EDUCATION-OPER	02.270
124	ELEM & SEC EDUCATION-OPER	02.275
125	ELEM & SEC EDUCATION-OPER	02.275
126	ELEM & SEC EDUCATION-OPER	02.275
127	ELEM & SEC EDUCATION-OPER	02.275
128	ELEM & SEC EDUCATION-OPER	02.275
129	ELEM & SEC EDUCATION-OPER	02.275
130	ELEM & SEC EDUCATION-OPER	02.275
131	ELEM & SEC EDUCATION-OPER	02.275
132	ELEM & SEC EDUCATION-OPER	02.280
133	ELEM & SEC EDUCATION-OPER	02.285
134	ELEM & SEC EDUCATION-OPER	02.290
135	ELEM & SEC EDUCATION-OPER	02.295
136	ELEM & SEC EDUCATION-OPER	02.300
137	ELEM & SEC EDUCATION-OPER	02.305
138	ELEM & SEC EDUCATION-OPER	02.310
139	ELEM & SEC EDUCATION-OPER	02.315
140	ELEM & SEC EDUCATION-OPER	02.320
141	ELEM & SEC EDUCATION-OPER	02.325
142	DHEWD-OPERATING	03.005
143	DHEWD-OPERATING	03.005
144	DHEWD-OPERATING	03.005
145	DHEWD-OPERATING	03.005
146	DHEWD-OPERATING	03.005
147	DHEWD-OPERATING	03.005
148	DHEWD-OPERATING	03.005
149	DHEWD-OPERATING	03.006
150	DHEWD-OPERATING	03.006
151	DHEWD-OPERATING	03.006
152	DHEWD-OPERATING	03.006
153	DHEWD-OPERATING	03.006
154	DHEWD-OPERATING	03.006
155	DHEWD-OPERATING	03.006
156	DHEWD-OPERATING	03.006
157	DHEWD-OPERATING	03.006
158	DHEWD-OPERATING	03.006
159	DHEWD-OPERATING	03.006
160	DHEWD-OPERATING	03.006
161	DHEWD-OPERATING	03.006
162	DHEWD-OPERATING	03.006
163	DHEWD-OPERATING	03.006
164	DHEWD-OPERATING	03.006
165	DHEWD-OPERATING	03.006
166	DHEWD-OPERATING	03.006
167	DHEWD-OPERATING	03.006
168	DHEWD-OPERATING	03.007
169	DHEWD-OPERATING	03.007
170	DHEWD-OPERATING	03.007
171	DHEWD-OPERATING	03.010
172	DHEWD-OPERATING	03.010
173	DHEWD-OPERATING	03.015
174	DHEWD-OPERATING	03.020

Exhibit A

#	Agnecy	Budget Appropriation Line
175	DHEWD-OPERATING	03.025
176	DHEWD-OPERATING	03.025
177	DHEWD-OPERATING	03.030
178	DHEWD-OPERATING	03.040
179	DHEWD-OPERATING	03.040
180	DHEWD-OPERATING	03.040
181	DHEWD-OPERATING	03.045
182	DHEWD-OPERATING	03.050
183	DHEWD-OPERATING	03.050
184	DHEWD-OPERATING	03.050
185	DHEWD-OPERATING	03.050
186	DHEWD-OPERATING	03.050
187	DHEWD-OPERATING	03.055
188	DHEWD-OPERATING	03.060
189	DHEWD-OPERATING	03.060
190	DHEWD-OPERATING	03.060
191	DHEWD-OPERATING	03.065
192	DHEWD-OPERATING	03.070
193	DHEWD-OPERATING	03.075
194	DHEWD-OPERATING	03.076
195	DHEWD-OPERATING	03.080
196	DHEWD-OPERATING	03.080
197	DHEWD-OPERATING	03.080
198	DHEWD-OPERATING	03.080
199	DHEWD-OPERATING	03.095
200	DHEWD-OPERATING	03.100
201	DHEWD-OPERATING	03.105
202	DHEWD-OPERATING	03.105
203	DHEWD-OPERATING	03.105
204	DHEWD-OPERATING	03.105
205	DHEWD-OPERATING	03.105
206	DHEWD-OPERATING	03.110
207	DHEWD-OPERATING	03.115
208	DHEWD-OPERATING	03.120
209	DHEWD-OPERATING	03.125
210	DHEWD-OPERATING	03.130
211	DHEWD-OPERATING	03.135
212	DHEWD-OPERATING	03.135
213	DHEWD-OPERATING	03.135
214	DHEWD-OPERATING	03.135
215	DHEWD-OPERATING	03.135
216	DHEWD-OPERATING	03.135
217	DHEWD-OPERATING	03.135
218	DHEWD-OPERATING	03.135
219	DHEWD-OPERATING	03.140
220	DHEWD-OPERATING	03.140
221	DHEWD-OPERATING	03.140
222	DHEWD-OPERATING	03.140
223	DHEWD-OPERATING	03.140
224	DHEWD-OPERATING	03.140
225	DHEWD-OPERATING	03.140
226	DHEWD-OPERATING	03.140
227	DHEWD-OPERATING	03.140
228	DHEWD-OPERATING	03.140
229	DHEWD-OPERATING	03.145
230	DHEWD-OPERATING	03.150
231	DHEWD-OPERATING	03.155
232	DHEWD-OPERATING	03.156

Exhibit A

#	Agnecy	Budget Appropriation Line
233	DHEWD-OPERATING	03.200
234	DHEWD-OPERATING	03.200
235	DHEWD-OPERATING	03.200
236	DHEWD-OPERATING	03.200
237	DHEWD-OPERATING	03.200
238	DHEWD-OPERATING	03.200
239	DHEWD-OPERATING	03.200
240	DHEWD-OPERATING	03.200
241	DHEWD-OPERATING	03.200
242	DHEWD-OPERATING	03.200
243	DHEWD-OPERATING	03.200
244	DHEWD-OPERATING	03.200
245	DHEWD-OPERATING	03.200
246	DHEWD-OPERATING	03.200
247	DHEWD-OPERATING	03.200
248	DHEWD-OPERATING	03.200
249	DHEWD-OPERATING	03.200
250	DHEWD-OPERATING	03.200
251	DHEWD-OPERATING	03.200
252	DHEWD-OPERATING	03.200
253	DHEWD-OPERATING	03.200
254	DHEWD-OPERATING	03.200
255	DHEWD-OPERATING	03.200
256	DHEWD-OPERATING	03.200
257	DHEWD-OPERATING	03.200
258	DHEWD-OPERATING	03.200
259	DHEWD-OPERATING	03.200
260	DHEWD-OPERATING	03.200
261	DHEWD-OPERATING	03.200
262	DHEWD-OPERATING	03.200
263	DHEWD-OPERATING	03.200
264	DHEWD-OPERATING	03.200
265	DHEWD-OPERATING	03.200
266	DHEWD-OPERATING	03.200
267	DHEWD-OPERATING	03.200
268	DHEWD-OPERATING	03.200
269	DHEWD-OPERATING	03.200
270	DHEWD-OPERATING	03.200
271	DHEWD-OPERATING	03.200
272	DHEWD-OPERATING	03.200
273	DHEWD-OPERATING	03.200
274	DHEWD-OPERATING	03.200
275	DHEWD-OPERATING	03.200
276	DHEWD-OPERATING	03.200
277	DHEWD-OPERATING	03.200
278	DHEWD-OPERATING	03.200
279	DHEWD-OPERATING	03.200
280	DHEWD-OPERATING	03.200
281	DHEWD-OPERATING	03.200
282	DHEWD-OPERATING	03.205
283	DHEWD-OPERATING	03.205
284	DHEWD-OPERATING	03.205
285	DHEWD-OPERATING	03.210
286	DHEWD-OPERATING	03.210
287	DHEWD-OPERATING	03.210
288	DHEWD-OPERATING	03.215
289	DHEWD-OPERATING	03.215
290	DHEWD-OPERATING	03.215

Exhibit A

#	Agnecy	Budget Appropriation Line
291	DHEWD-OPERATING	03.220
292	DHEWD-OPERATING	03.220
293	DHEWD-OPERATING	03.220
294	DHEWD-OPERATING	03.225
295	DHEWD-OPERATING	03.225
296	DHEWD-OPERATING	03.225
297	DHEWD-OPERATING	03.225
298	DHEWD-OPERATING	03.230
299	DHEWD-OPERATING	03.230
300	DHEWD-OPERATING	03.230
301	DHEWD-OPERATING	03.235
302	DHEWD-OPERATING	03.235
303	DHEWD-OPERATING	03.235
304	DHEWD-OPERATING	03.240
305	DHEWD-OPERATING	03.240
306	DHEWD-OPERATING	03.240
307	DHEWD-OPERATING	03.245
308	DHEWD-OPERATING	03.245
309	DHEWD-OPERATING	03.245
310	DHEWD-OPERATING	03.250
311	DHEWD-OPERATING	03.250
312	DHEWD-OPERATING	03.250
313	DHEWD-OPERATING	03.255
314	DHEWD-OPERATING	03.255
315	DHEWD-OPERATING	03.255
316	DHEWD-OPERATING	03.255
317	DHEWD-OPERATING	03.260
318	DHEWD-OPERATING	03.265
319	DHEWD-OPERATING	03.270
320	DHEWD-OPERATING	03.270
321	DHEWD-OPERATING	03.275
322	DHEWD-OPERATING	03.280
323	DHEWD-OPERATING	03.285
324	DHEWD-OPERATING	03.290
325	DHEWD-OPERATING	03.295
326	REVENUE-OPERATING	04.005
327	REVENUE-OPERATING	04.005
328	REVENUE-OPERATING	04.005
329	REVENUE-OPERATING	04.005
330	REVENUE-OPERATING	04.005
331	REVENUE-OPERATING	04.005
332	REVENUE-OPERATING	04.005
333	REVENUE-OPERATING	04.005
334	REVENUE-OPERATING	04.005
335	REVENUE-OPERATING	04.005
336	REVENUE-OPERATING	04.005
337	REVENUE-OPERATING	04.005
338	REVENUE-OPERATING	04.005
339	REVENUE-OPERATING	04.005
340	REVENUE-OPERATING	04.005
341	REVENUE-OPERATING	04.005
342	REVENUE-OPERATING	04.005
343	REVENUE-OPERATING	04.005
344	REVENUE-OPERATING	04.006
345	REVENUE-OPERATING	04.006
346	REVENUE-OPERATING	04.006
347	REVENUE-OPERATING	04.010
348	REVENUE-OPERATING	04.010

Exhibit A

#	Agnecy	Budget Appropriation Line
349	REVENUE-OPERATING	04.010
350	REVENUE-OPERATING	04.010
351	REVENUE-OPERATING	04.010
352	REVENUE-OPERATING	04.010
353	REVENUE-OPERATING	04.010
354	REVENUE-OPERATING	04.010
355	REVENUE-OPERATING	04.010
356	REVENUE-OPERATING	04.010
357	REVENUE-OPERATING	04.010
358	REVENUE-OPERATING	04.015
359	REVENUE-OPERATING	04.015
360	REVENUE-OPERATING	04.015
361	REVENUE-OPERATING	04.015
362	REVENUE-OPERATING	04.015
363	REVENUE-OPERATING	04.015
364	REVENUE-OPERATING	04.015
365	REVENUE-OPERATING	04.015
366	REVENUE-OPERATING	04.020
367	REVENUE-OPERATING	04.020
368	REVENUE-OPERATING	04.020
369	REVENUE-OPERATING	04.020
370	REVENUE-OPERATING	04.020
371	REVENUE-OPERATING	04.020
372	REVENUE-OPERATING	04.020
373	REVENUE-OPERATING	04.020
374	REVENUE-OPERATING	04.025
375	REVENUE-OPERATING	04.025
376	REVENUE-OPERATING	04.025
377	REVENUE-OPERATING	04.025
378	REVENUE-OPERATING	04.025
379	REVENUE-OPERATING	04.025
380	REVENUE-OPERATING	04.025
381	REVENUE-OPERATING	04.025
382	REVENUE-OPERATING	04.025
383	REVENUE-OPERATING	04.025
384	REVENUE-OPERATING	04.030
385	REVENUE-OPERATING	04.035
386	REVENUE-OPERATING	04.050
387	REVENUE-OPERATING	04.065
388	REVENUE-OPERATING	04.065
389	REVENUE-OPERATING	04.065
390	REVENUE-OPERATING	04.065
391	REVENUE-OPERATING	04.065
392	REVENUE-OPERATING	04.065
393	REVENUE-OPERATING	04.070
394	REVENUE-OPERATING	04.075
395	REVENUE-OPERATING	04.080
396	REVENUE-OPERATING	04.085
397	REVENUE-OPERATING	04.090
398	REVENUE-OPERATING	04.090
399	REVENUE-OPERATING	04.090
400	REVENUE-OPERATING	04.095
401	REVENUE-OPERATING	04.115
402	REVENUE-OPERATING	04.115
403	REVENUE-OPERATING	04.120
404	REVENUE-OPERATING	04.125
405	REVENUE-OPERATING	04.130
406	REVENUE-OPERATING	04.140

Exhibit A

#	Agnecy	Budget Appropriation Line
407	REVENUE-OPERATING	04.145
408	REVENUE-OPERATING	04.145
409	REVENUE-OPERATING	04.145
410	REVENUE-OPERATING	04.145
411	REVENUE-OPERATING	04.145
412	REVENUE-OPERATING	04.145
413	REVENUE-OPERATING	04.145
414	REVENUE-OPERATING	04.145
415	REVENUE-OPERATING	04.145
416	REVENUE-OPERATING	04.145
417	REVENUE-OPERATING	04.150
418	REVENUE-OPERATING	04.155
419	REVENUE-OPERATING	04.160
420	REVENUE-OPERATING	04.165
421	REVENUE-OPERATING	04.165
422	REVENUE-OPERATING	04.165
423	REVENUE-OPERATING	04.170
424	REVENUE-OPERATING	04.175
425	REVENUE-OPERATING	04.180
426	REVENUE-OPERATING	04.180
427	REVENUE-OPERATING	04.180
428	REVENUE-OPERATING	04.180
429	REVENUE-OPERATING	04.180
430	REVENUE-OPERATING	04.185
431	REVENUE-OPERATING	04.190
432	REVENUE-OPERATING	04.195
433	MO TRANSPORTATION-OPER	04.400
434	MO TRANSPORTATION-OPER	04.400
435	MO TRANSPORTATION-OPER	04.400
436	MO TRANSPORTATION-OPER	04.400
437	MO TRANSPORTATION-OPER	04.400
438	MO TRANSPORTATION-OPER	04.400
439	MO TRANSPORTATION-OPER	04.401
440	MO TRANSPORTATION-OPER	04.401
441	MO TRANSPORTATION-OPER	04.405
442	MO TRANSPORTATION-OPER	04.405
443	MO TRANSPORTATION-OPER	04.405
444	MO TRANSPORTATION-OPER	04.405
445	MO TRANSPORTATION-OPER	04.405
446	MO TRANSPORTATION-OPER	04.405
447	MO TRANSPORTATION-OPER	04.405
448	MO TRANSPORTATION-OPER	04.405
449	MO TRANSPORTATION-OPER	04.405
450	MO TRANSPORTATION-OPER	04.405
451	MO TRANSPORTATION-OPER	04.405
452	MO TRANSPORTATION-OPER	04.405
453	MO TRANSPORTATION-OPER	04.405
454	MO TRANSPORTATION-OPER	04.405
455	MO TRANSPORTATION-OPER	04.410
456	MO TRANSPORTATION-OPER	04.410
457	MO TRANSPORTATION-OPER	04.410
458	MO TRANSPORTATION-OPER	04.410
459	MO TRANSPORTATION-OPER	04.410
460	MO TRANSPORTATION-OPER	04.413
461	MO TRANSPORTATION-OPER	04.415
462	MO TRANSPORTATION-OPER	04.420
463	MO TRANSPORTATION-OPER	04.425
464	MO TRANSPORTATION-OPER	04.425

Exhibit A

#	Agnecy	Budget Appropriation Line
465	MO TRANSPORTATION-OPER	04.425
466	MO TRANSPORTATION-OPER	04.425
467	MO TRANSPORTATION-OPER	04.426
468	MO TRANSPORTATION-OPER	04.427
469	MO TRANSPORTATION-OPER	04.427
470	MO TRANSPORTATION-OPER	04.427
471	MO TRANSPORTATION-OPER	04.427
472	MO TRANSPORTATION-OPER	04.435
473	MO TRANSPORTATION-OPER	04.435
474	MO TRANSPORTATION-OPER	04.435
475	MO TRANSPORTATION-OPER	04.435
476	MO TRANSPORTATION-OPER	04.435
477	MO TRANSPORTATION-OPER	04.435
478	MO TRANSPORTATION-OPER	04.435
479	MO TRANSPORTATION-OPER	04.435
480	MO TRANSPORTATION-OPER	04.437
481	MO TRANSPORTATION-OPER	04.437
482	MO TRANSPORTATION-OPER	04.437
483	MO TRANSPORTATION-OPER	04.440
484	MO TRANSPORTATION-OPER	04.440
485	MO TRANSPORTATION-OPER	04.445
486	MO TRANSPORTATION-OPER	04.445
487	MO TRANSPORTATION-OPER	04.450
488	MO TRANSPORTATION-OPER	04.455
489	MO TRANSPORTATION-OPER	04.455
490	MO TRANSPORTATION-OPER	04.455
491	MO TRANSPORTATION-OPER	04.455
492	MO TRANSPORTATION-OPER	04.455
493	MO TRANSPORTATION-OPER	04.455
494	MO TRANSPORTATION-OPER	04.455
495	MO TRANSPORTATION-OPER	04.455
496	MO TRANSPORTATION-OPER	04.455
497	MO TRANSPORTATION-OPER	04.455
498	MO TRANSPORTATION-OPER	04.460
499	MO TRANSPORTATION-OPER	04.460
500	MO TRANSPORTATION-OPER	04.460
501	MO TRANSPORTATION-OPER	04.460
502	MO TRANSPORTATION-OPER	04.465
503	MO TRANSPORTATION-OPER	04.470
504	MO TRANSPORTATION-OPER	04.475
505	MO TRANSPORTATION-OPER	04.480
506	MO TRANSPORTATION-OPER	04.480
507	MO TRANSPORTATION-OPER	04.485
508	MO TRANSPORTATION-OPER	04.490
509	MO TRANSPORTATION-OPER	04.495
510	MO TRANSPORTATION-OPER	04.500
511	MO TRANSPORTATION-OPER	04.505
512	MO TRANSPORTATION-OPER	04.505
513	MO TRANSPORTATION-OPER	04.510
514	MO TRANSPORTATION-OPER	04.515
515	MO TRANSPORTATION-OPER	04.520
516	MO TRANSPORTATION-OPER	04.525
517	MO TRANSPORTATION-OPER	04.525
518	MO TRANSPORTATION-OPER	04.530
519	MO TRANSPORTATION-OPER	04.535
520	MO TRANSPORTATION-OPER	04.535
521	MO TRANSPORTATION-OPER	04.540
522	MO TRANSPORTATION-OPER	04.545

Exhibit A

#	Agnecy	Budget Appropriation Line
523	MO TRANSPORTATION-OPER	04.550
524	OFFICE ADMINISTRATION-OPER	05.005
525	OFFICE ADMINISTRATION-OPER	05.005
526	OFFICE ADMINISTRATION-OPER	05.005
527	OFFICE ADMINISTRATION-OPER	05.005
528	OFFICE ADMINISTRATION-OPER	05.005
529	OFFICE ADMINISTRATION-OPER	05.005
530	OFFICE ADMINISTRATION-OPER	05.005
531	OFFICE ADMINISTRATION-OPER	05.005
532	OFFICE ADMINISTRATION-OPER	05.006
533	OFFICE ADMINISTRATION-OPER	05.006
534	OFFICE ADMINISTRATION-OPER	05.006
535	OFFICE ADMINISTRATION-OPER	05.007
536	OFFICE ADMINISTRATION-OPER	05.010
537	OFFICE ADMINISTRATION-OPER	05.010
538	OFFICE ADMINISTRATION-OPER	05.015
539	OFFICE ADMINISTRATION-OPER	05.015
540	OFFICE ADMINISTRATION-OPER	05.015
541	OFFICE ADMINISTRATION-OPER	05.015
542	OFFICE ADMINISTRATION-OPER	05.015
543	OFFICE ADMINISTRATION-OPER	05.015
544	OFFICE ADMINISTRATION-OPER	05.020
545	OFFICE ADMINISTRATION-OPER	05.020
546	OFFICE ADMINISTRATION-OPER	05.020
547	OFFICE ADMINISTRATION-OPER	05.020
548	OFFICE ADMINISTRATION-OPER	05.020
549	OFFICE ADMINISTRATION-OPER	05.020
550	OFFICE ADMINISTRATION-OPER	05.020
551	OFFICE ADMINISTRATION-OPER	05.020
552	OFFICE ADMINISTRATION-OPER	05.020
553	OFFICE ADMINISTRATION-OPER	05.025
554	OFFICE ADMINISTRATION-OPER	05.025
555	OFFICE ADMINISTRATION-OPER	05.025
556	OFFICE ADMINISTRATION-OPER	05.025
557	OFFICE ADMINISTRATION-OPER	05.025
558	OFFICE ADMINISTRATION-OPER	05.025
559	OFFICE ADMINISTRATION-OPER	05.025
560	OFFICE ADMINISTRATION-OPER	05.025
561	OFFICE ADMINISTRATION-OPER	05.025
562	OFFICE ADMINISTRATION-OPER	05.025
563	OFFICE ADMINISTRATION-OPER	05.025
564	OFFICE ADMINISTRATION-OPER	05.025
565	OFFICE ADMINISTRATION-OPER	05.025
566	OFFICE ADMINISTRATION-OPER	05.025
567	OFFICE ADMINISTRATION-OPER	05.025
568	OFFICE ADMINISTRATION-OPER	05.025
569	OFFICE ADMINISTRATION-OPER	05.025
570	OFFICE ADMINISTRATION-OPER	05.025
571	OFFICE ADMINISTRATION-OPER	05.025
572	OFFICE ADMINISTRATION-OPER	05.025
573	OFFICE ADMINISTRATION-OPER	05.025
574	OFFICE ADMINISTRATION-OPER	05.025
575	OFFICE ADMINISTRATION-OPER	05.025
576	OFFICE ADMINISTRATION-OPER	05.025
577	OFFICE ADMINISTRATION-OPER	05.025
578	OFFICE ADMINISTRATION-OPER	05.025
579	OFFICE ADMINISTRATION-OPER	05.025
580	OFFICE ADMINISTRATION-OPER	05.025

Exhibit A

#	Agnecy	Budget Appropriation Line
581	OFFICE ADMINISTRATION-OPER	05.025
582	OFFICE ADMINISTRATION-OPER	05.025
583	OFFICE ADMINISTRATION-OPER	05.025
584	OFFICE ADMINISTRATION-OPER	05.025
585	OFFICE ADMINISTRATION-OPER	05.025
586	OFFICE ADMINISTRATION-OPER	05.025
587	OFFICE ADMINISTRATION-OPER	05.025
588	OFFICE ADMINISTRATION-OPER	05.025
589	OFFICE ADMINISTRATION-OPER	05.025
590	OFFICE ADMINISTRATION-OPER	05.025
591	OFFICE ADMINISTRATION-OPER	05.025
592	OFFICE ADMINISTRATION-OPER	05.025
593	OFFICE ADMINISTRATION-OPER	05.025
594	OFFICE ADMINISTRATION-OPER	05.025
595	OFFICE ADMINISTRATION-OPER	05.025
596	OFFICE ADMINISTRATION-OPER	05.025
597	OFFICE ADMINISTRATION-OPER	05.025
598	OFFICE ADMINISTRATION-OPER	05.025
599	OFFICE ADMINISTRATION-OPER	05.025
600	OFFICE ADMINISTRATION-OPER	05.025
601	OFFICE ADMINISTRATION-OPER	05.025
602	OFFICE ADMINISTRATION-OPER	05.025
603	OFFICE ADMINISTRATION-OPER	05.025
604	OFFICE ADMINISTRATION-OPER	05.025
605	OFFICE ADMINISTRATION-OPER	05.025
606	OFFICE ADMINISTRATION-OPER	05.025
607	OFFICE ADMINISTRATION-OPER	05.025
608	OFFICE ADMINISTRATION-OPER	05.025
609	OFFICE ADMINISTRATION-OPER	05.025
610	OFFICE ADMINISTRATION-OPER	05.025
611	OFFICE ADMINISTRATION-OPER	05.025
612	OFFICE ADMINISTRATION-OPER	05.025
613	OFFICE ADMINISTRATION-OPER	05.025
614	OFFICE ADMINISTRATION-OPER	05.025
615	OFFICE ADMINISTRATION-OPER	05.025
616	OFFICE ADMINISTRATION-OPER	05.025
617	OFFICE ADMINISTRATION-OPER	05.025
618	OFFICE ADMINISTRATION-OPER	05.025
619	OFFICE ADMINISTRATION-OPER	05.025
620	OFFICE ADMINISTRATION-OPER	05.025
621	OFFICE ADMINISTRATION-OPER	05.025
622	OFFICE ADMINISTRATION-OPER	05.025
623	OFFICE ADMINISTRATION-OPER	05.025
624	OFFICE ADMINISTRATION-OPER	05.025
625	OFFICE ADMINISTRATION-OPER	05.025
626	OFFICE ADMINISTRATION-OPER	05.025
627	OFFICE ADMINISTRATION-OPER	05.025
628	OFFICE ADMINISTRATION-OPER	05.025
629	OFFICE ADMINISTRATION-OPER	05.025
630	OFFICE ADMINISTRATION-OPER	05.025
631	OFFICE ADMINISTRATION-OPER	05.025
632	OFFICE ADMINISTRATION-OPER	05.025
633	OFFICE ADMINISTRATION-OPER	05.025
634	OFFICE ADMINISTRATION-OPER	05.025
635	OFFICE ADMINISTRATION-OPER	05.025
636	OFFICE ADMINISTRATION-OPER	05.025
637	OFFICE ADMINISTRATION-OPER	05.025
638	OFFICE ADMINISTRATION-OPER	05.025

Exhibit A

#	Agnecy	Budget Appropriation Line
639	OFFICE ADMINISTRATION-OPER	05.025
640	OFFICE ADMINISTRATION-OPER	05.025
641	OFFICE ADMINISTRATION-OPER	05.025
642	OFFICE ADMINISTRATION-OPER	05.025
643	OFFICE ADMINISTRATION-OPER	05.025
644	OFFICE ADMINISTRATION-OPER	05.030
645	OFFICE ADMINISTRATION-OPER	05.030
646	OFFICE ADMINISTRATION-OPER	05.030
647	OFFICE ADMINISTRATION-OPER	05.030
648	OFFICE ADMINISTRATION-OPER	05.030
649	OFFICE ADMINISTRATION-OPER	05.030
650	OFFICE ADMINISTRATION-OPER	05.030
651	OFFICE ADMINISTRATION-OPER	05.030
652	OFFICE ADMINISTRATION-OPER	05.030
653	OFFICE ADMINISTRATION-OPER	05.030
654	OFFICE ADMINISTRATION-OPER	05.030
655	OFFICE ADMINISTRATION-OPER	05.030
656	OFFICE ADMINISTRATION-OPER	05.030
657	OFFICE ADMINISTRATION-OPER	05.030
658	OFFICE ADMINISTRATION-OPER	05.030
659	OFFICE ADMINISTRATION-OPER	05.030
660	OFFICE ADMINISTRATION-OPER	05.030
661	OFFICE ADMINISTRATION-OPER	05.030
662	OFFICE ADMINISTRATION-OPER	05.030
663	OFFICE ADMINISTRATION-OPER	05.030
664	OFFICE ADMINISTRATION-OPER	05.030
665	OFFICE ADMINISTRATION-OPER	05.030
666	OFFICE ADMINISTRATION-OPER	05.030
667	OFFICE ADMINISTRATION-OPER	05.030
668	OFFICE ADMINISTRATION-OPER	05.030
669	OFFICE ADMINISTRATION-OPER	05.030
670	OFFICE ADMINISTRATION-OPER	05.030
671	OFFICE ADMINISTRATION-OPER	05.030
672	OFFICE ADMINISTRATION-OPER	05.030
673	OFFICE ADMINISTRATION-OPER	05.030
674	OFFICE ADMINISTRATION-OPER	05.030
675	OFFICE ADMINISTRATION-OPER	05.030
676	OFFICE ADMINISTRATION-OPER	05.030
677	OFFICE ADMINISTRATION-OPER	05.030
678	OFFICE ADMINISTRATION-OPER	05.030
679	OFFICE ADMINISTRATION-OPER	05.030
680	OFFICE ADMINISTRATION-OPER	05.030
681	OFFICE ADMINISTRATION-OPER	05.030
682	OFFICE ADMINISTRATION-OPER	05.030
683	OFFICE ADMINISTRATION-OPER	05.030
684	OFFICE ADMINISTRATION-OPER	05.030
685	OFFICE ADMINISTRATION-OPER	05.030
686	OFFICE ADMINISTRATION-OPER	05.030
687	OFFICE ADMINISTRATION-OPER	05.030
688	OFFICE ADMINISTRATION-OPER	05.030
689	OFFICE ADMINISTRATION-OPER	05.030
690	OFFICE ADMINISTRATION-OPER	05.030
691	OFFICE ADMINISTRATION-OPER	05.030
692	OFFICE ADMINISTRATION-OPER	05.030
693	OFFICE ADMINISTRATION-OPER	05.030
694	OFFICE ADMINISTRATION-OPER	05.030
695	OFFICE ADMINISTRATION-OPER	05.030
696	OFFICE ADMINISTRATION-OPER	05.030

Exhibit A

#	Agnecy	Budget Appropriation Line
697	OFFICE ADMINISTRATION-OPER	05.030
698	OFFICE ADMINISTRATION-OPER	05.030
699	OFFICE ADMINISTRATION-OPER	05.030
700	OFFICE ADMINISTRATION-OPER	05.030
701	OFFICE ADMINISTRATION-OPER	05.030
702	OFFICE ADMINISTRATION-OPER	05.030
703	OFFICE ADMINISTRATION-OPER	05.030
704	OFFICE ADMINISTRATION-OPER	05.030
705	OFFICE ADMINISTRATION-OPER	05.030
706	OFFICE ADMINISTRATION-OPER	05.030
707	OFFICE ADMINISTRATION-OPER	05.030
708	OFFICE ADMINISTRATION-OPER	05.030
709	OFFICE ADMINISTRATION-OPER	05.030
710	OFFICE ADMINISTRATION-OPER	05.030
711	OFFICE ADMINISTRATION-OPER	05.030
712	OFFICE ADMINISTRATION-OPER	05.030
713	OFFICE ADMINISTRATION-OPER	05.030
714	OFFICE ADMINISTRATION-OPER	05.030
715	OFFICE ADMINISTRATION-OPER	05.030
716	OFFICE ADMINISTRATION-OPER	05.030
717	OFFICE ADMINISTRATION-OPER	05.030
718	OFFICE ADMINISTRATION-OPER	05.030
719	OFFICE ADMINISTRATION-OPER	05.030
720	OFFICE ADMINISTRATION-OPER	05.030
721	OFFICE ADMINISTRATION-OPER	05.030
722	OFFICE ADMINISTRATION-OPER	05.030
723	OFFICE ADMINISTRATION-OPER	05.030
724	OFFICE ADMINISTRATION-OPER	05.030
725	OFFICE ADMINISTRATION-OPER	05.030
726	OFFICE ADMINISTRATION-OPER	05.030
727	OFFICE ADMINISTRATION-OPER	05.030
728	OFFICE ADMINISTRATION-OPER	05.030
729	OFFICE ADMINISTRATION-OPER	05.030
730	OFFICE ADMINISTRATION-OPER	05.030
731	OFFICE ADMINISTRATION-OPER	05.030
732	OFFICE ADMINISTRATION-OPER	05.030
733	OFFICE ADMINISTRATION-OPER	05.030
734	OFFICE ADMINISTRATION-OPER	05.030
735	OFFICE ADMINISTRATION-OPER	05.030
736	OFFICE ADMINISTRATION-OPER	05.030
737	OFFICE ADMINISTRATION-OPER	05.030
738	OFFICE ADMINISTRATION-OPER	05.030
739	OFFICE ADMINISTRATION-OPER	05.030
740	OFFICE ADMINISTRATION-OPER	05.030
741	OFFICE ADMINISTRATION-OPER	05.030
742	OFFICE ADMINISTRATION-OPER	05.030
743	OFFICE ADMINISTRATION-OPER	05.030
744	OFFICE ADMINISTRATION-OPER	05.030
745	OFFICE ADMINISTRATION-OPER	05.030
746	OFFICE ADMINISTRATION-OPER	05.035
747	OFFICE ADMINISTRATION-OPER	05.040
748	OFFICE ADMINISTRATION-OPER	05.040
749	OFFICE ADMINISTRATION-OPER	05.045
750	OFFICE ADMINISTRATION-OPER	05.045
751	OFFICE ADMINISTRATION-OPER	05.045
752	OFFICE ADMINISTRATION-OPER	05.045
753	OFFICE ADMINISTRATION-OPER	05.050
754	OFFICE ADMINISTRATION-OPER	05.050

Exhibit A

#	Agnecy	Budget Appropriation Line
755	OFFICE ADMINISTRATION-OPER	05.050
756	OFFICE ADMINISTRATION-OPER	05.050
757	OFFICE ADMINISTRATION-OPER	05.050
758	OFFICE ADMINISTRATION-OPER	05.050
759	OFFICE ADMINISTRATION-OPER	05.055
760	OFFICE ADMINISTRATION-OPER	05.055
761	OFFICE ADMINISTRATION-OPER	05.060
762	OFFICE ADMINISTRATION-OPER	05.060
763	OFFICE ADMINISTRATION-OPER	05.060
764	OFFICE ADMINISTRATION-OPER	05.065
765	OFFICE ADMINISTRATION-OPER	05.070
766	OFFICE ADMINISTRATION-OPER	05.070
767	OFFICE ADMINISTRATION-OPER	05.070
768	OFFICE ADMINISTRATION-OPER	05.070
769	OFFICE ADMINISTRATION-OPER	05.070
770	OFFICE ADMINISTRATION-OPER	05.070
771	OFFICE ADMINISTRATION-OPER	05.075
772	OFFICE ADMINISTRATION-OPER	05.080
773	OFFICE ADMINISTRATION-OPER	05.085
774	OFFICE ADMINISTRATION-OPER	05.085
775	OFFICE ADMINISTRATION-OPER	05.085
776	OFFICE ADMINISTRATION-OPER	05.090
777	OFFICE ADMINISTRATION-OPER	05.095
778	OFFICE ADMINISTRATION-OPER	05.100
779	OFFICE ADMINISTRATION-OPER	05.100
780	OFFICE ADMINISTRATION-OPER	05.100
781	OFFICE ADMINISTRATION-OPER	05.100
782	OFFICE ADMINISTRATION-OPER	05.105
783	OFFICE ADMINISTRATION-OPER	05.105
784	OFFICE ADMINISTRATION-OPER	05.105
785	OFFICE ADMINISTRATION-OPER	05.105
786	OFFICE ADMINISTRATION-OPER	05.110
787	OFFICE ADMINISTRATION-OPER	05.115
788	OFFICE ADMINISTRATION-OPER	05.120
789	OFFICE ADMINISTRATION-OPER	05.125
790	OFFICE ADMINISTRATION-OPER	05.130
791	OFFICE ADMINISTRATION-OPER	05.135
792	OFFICE ADMINISTRATION-OPER	05.140
793	OFFICE ADMINISTRATION-OPER	05.145
794	OFFICE ADMINISTRATION-OPER	05.145
795	OFFICE ADMINISTRATION-OPER	05.145
796	OFFICE ADMINISTRATION-OPER	05.150
797	OFFICE ADMINISTRATION-OPER	05.155
798	OFFICE ADMINISTRATION-OPER	05.160
799	OFFICE ADMINISTRATION-OPER	05.160
800	OFFICE ADMINISTRATION-OPER	05.160
801	OFFICE ADMINISTRATION-OPER	05.160
802	OFFICE ADMINISTRATION-OPER	05.165
803	OFFICE ADMINISTRATION-OPER	05.165
804	OFFICE ADMINISTRATION-OPER	05.165
805	OFFICE ADMINISTRATION-OPER	05.165
806	OFFICE ADMINISTRATION-OPER	05.170
807	OFFICE ADMINISTRATION-OPER	05.170
808	OFFICE ADMINISTRATION-OPER	05.170
809	OFFICE ADMINISTRATION-OPER	05.170
810	OFFICE ADMINISTRATION-OPER	05.175
811	OFFICE ADMINISTRATION-OPER	05.175
812	OFFICE ADMINISTRATION-OPER	05.180

Exhibit A

#	Agnecy	Budget Appropriation Line
813	OFFICE ADMINISTRATION-OPER	05.180
814	OFFICE ADMINISTRATION-OPER	05.190
815	OFFICE ADMINISTRATION-OPER	05.190
816	OFFICE ADMINISTRATION-OPER	05.200
817	OFFICE ADMINISTRATION-OPER	05.205
818	OFFICE ADMINISTRATION-OPER	05.210
819	OFFICE ADMINISTRATION-OPER	05.215
820	OFFICE ADMINISTRATION-OPER	05.220
821	OFFICE ADMINISTRATION-OPER	05.225
822	OFFICE ADMINISTRATION-OPER	05.230
823	OFFICE ADMINISTRATION-OPER	05.235
824	OFFICE ADMINISTRATION-OPER	05.240
825	OFFICE ADMINISTRATION-OPER	05.245
826	OFFICE ADMINISTRATION-OPER	05.250
827	OFFICE ADMINISTRATION-OPER	05.250
828	OFFICE ADMINISTRATION-OPER	05.250
829	OFFICE ADMINISTRATION-OPER	05.255
830	OFFICE ADMINISTRATION-OPER	05.255
831	OFFICE ADMINISTRATION-OPER	05.260
832	OFFICE ADMINISTRATION-OPER	05.265
833	OFFICE ADMINISTRATION-OPER	05.270
834	OFFICE ADMINISTRATION-OPER	05.270
835	OFFICE ADMINISTRATION-OPER	05.275
836	OFFICE ADMINISTRATION-OPER	05.280
837	OFFICE ADMINISTRATION-OPER	05.285
838	OFFICE ADMINISTRATION-OPER	05.290
839	OFFICE ADMINISTRATION-OPER	05.295
840	OFFICE ADMINISTRATION-OPER	05.305
841	OFFICE ADMINISTRATION-OPER	05.450
842	OFFICE ADMINISTRATION-OPER	05.450
843	OFFICE ADMINISTRATION-OPER	05.450
844	OFFICE ADMINISTRATION-OPER	05.455
845	OFFICE ADMINISTRATION-OPER	05.460
846	OFFICE ADMINISTRATION-OPER	05.465
847	OFFICE ADMINISTRATION-OPER	05.465
848	OFFICE ADMINISTRATION-OPER	05.465
849	OFFICE ADMINISTRATION-OPER	05.470
850	OFFICE ADMINISTRATION-OPER	05.475
851	OFFICE ADMINISTRATION-OPER	05.480
852	OFFICE ADMINISTRATION-OPER	05.480
853	OFFICE ADMINISTRATION-OPER	05.480
854	OFFICE ADMINISTRATION-OPER	05.485
855	OFFICE ADMINISTRATION-OPER	05.490
856	OFFICE ADMINISTRATION-OPER	05.490
857	OFFICE ADMINISTRATION-OPER	05.490
858	OFFICE ADMINISTRATION-OPER	05.495
859	OFFICE ADMINISTRATION-OPER	05.505
860	OFFICE ADMINISTRATION-OPER	05.510
861	OFFICE ADMINISTRATION-OPER	05.515
862	OFFICE ADMINISTRATION-OPER	05.520
863	OFFICE ADMINISTRATION-OPER	05.520
864	OFFICE ADMINISTRATION-OPER	05.525
865	OFFICE ADMINISTRATION-OPER	05.525
866	OFFICE ADMINISTRATION-OPER	05.530
867	OFFICE ADMINISTRATION-OPER	05.530
868	AGRICULTURE-OPERATING	06.005
869	AGRICULTURE-OPERATING	06.005
870	AGRICULTURE-OPERATING	06.005

Exhibit A

#	Agnecy	Budget Appropriation Line
871	AGRICULTURE-OPERATING	06.005
872	AGRICULTURE-OPERATING	06.005
873	AGRICULTURE-OPERATING	06.005
874	AGRICULTURE-OPERATING	06.005
875	AGRICULTURE-OPERATING	06.005
876	AGRICULTURE-OPERATING	06.005
877	AGRICULTURE-OPERATING	06.005
878	AGRICULTURE-OPERATING	06.005
879	AGRICULTURE-OPERATING	06.005
880	AGRICULTURE-OPERATING	06.005
881	AGRICULTURE-OPERATING	06.005
882	AGRICULTURE-OPERATING	06.005
883	AGRICULTURE-OPERATING	06.005
884	AGRICULTURE-OPERATING	06.005
885	AGRICULTURE-OPERATING	06.005
886	AGRICULTURE-OPERATING	06.005
887	AGRICULTURE-OPERATING	06.005
888	AGRICULTURE-OPERATING	06.005
889	AGRICULTURE-OPERATING	06.006
890	AGRICULTURE-OPERATING	06.006
891	AGRICULTURE-OPERATING	06.006
892	AGRICULTURE-OPERATING	06.010
893	AGRICULTURE-OPERATING	06.015
894	AGRICULTURE-OPERATING	06.020
895	AGRICULTURE-OPERATING	06.020
896	AGRICULTURE-OPERATING	06.020
897	AGRICULTURE-OPERATING	06.020
898	AGRICULTURE-OPERATING	06.020
899	AGRICULTURE-OPERATING	06.020
900	AGRICULTURE-OPERATING	06.020
901	AGRICULTURE-OPERATING	06.020
902	AGRICULTURE-OPERATING	06.020
903	AGRICULTURE-OPERATING	06.020
904	AGRICULTURE-OPERATING	06.020
905	AGRICULTURE-OPERATING	06.020
906	AGRICULTURE-OPERATING	06.020
907	AGRICULTURE-OPERATING	06.020
908	AGRICULTURE-OPERATING	06.020
909	AGRICULTURE-OPERATING	06.020
910	AGRICULTURE-OPERATING	06.020
911	AGRICULTURE-OPERATING	06.025
912	AGRICULTURE-OPERATING	06.025
913	AGRICULTURE-OPERATING	06.030
914	AGRICULTURE-OPERATING	06.030
915	AGRICULTURE-OPERATING	06.035
916	AGRICULTURE-OPERATING	06.035
917	AGRICULTURE-OPERATING	06.035
918	AGRICULTURE-OPERATING	06.035
919	AGRICULTURE-OPERATING	06.035
920	AGRICULTURE-OPERATING	06.045
921	AGRICULTURE-OPERATING	06.055
922	AGRICULTURE-OPERATING	06.065
923	AGRICULTURE-OPERATING	06.070
924	AGRICULTURE-OPERATING	06.070
925	AGRICULTURE-OPERATING	06.070
926	AGRICULTURE-OPERATING	06.075
927	AGRICULTURE-OPERATING	06.085
928	AGRICULTURE-OPERATING	06.085

Exhibit A

#	Agnecy	Budget Appropriation Line
929	AGRICULTURE-OPERATING	06.085
930	AGRICULTURE-OPERATING	06.085
931	AGRICULTURE-OPERATING	06.085
932	AGRICULTURE-OPERATING	06.085
933	AGRICULTURE-OPERATING	06.085
934	AGRICULTURE-OPERATING	06.085
935	AGRICULTURE-OPERATING	06.085
936	AGRICULTURE-OPERATING	06.085
937	AGRICULTURE-OPERATING	06.085
938	AGRICULTURE-OPERATING	06.085
939	AGRICULTURE-OPERATING	06.085
940	AGRICULTURE-OPERATING	06.085
941	AGRICULTURE-OPERATING	06.085
942	AGRICULTURE-OPERATING	06.085
943	AGRICULTURE-OPERATING	06.085
944	AGRICULTURE-OPERATING	06.095
945	AGRICULTURE-OPERATING	06.095
946	AGRICULTURE-OPERATING	06.095
947	AGRICULTURE-OPERATING	06.095
948	AGRICULTURE-OPERATING	06.095
949	AGRICULTURE-OPERATING	06.095
950	AGRICULTURE-OPERATING	06.095
951	AGRICULTURE-OPERATING	06.095
952	AGRICULTURE-OPERATING	06.095
953	AGRICULTURE-OPERATING	06.100
954	AGRICULTURE-OPERATING	06.100
955	AGRICULTURE-OPERATING	06.100
956	AGRICULTURE-OPERATING	06.105
957	AGRICULTURE-OPERATING	06.105
958	AGRICULTURE-OPERATING	06.105
959	AGRICULTURE-OPERATING	06.105
960	AGRICULTURE-OPERATING	06.105
961	AGRICULTURE-OPERATING	06.105
962	AGRICULTURE-OPERATING	06.105
963	AGRICULTURE-OPERATING	06.105
964	AGRICULTURE-OPERATING	06.105
965	AGRICULTURE-OPERATING	06.105
966	AGRICULTURE-OPERATING	06.105
967	AGRICULTURE-OPERATING	06.105
968	AGRICULTURE-OPERATING	06.105
969	AGRICULTURE-OPERATING	06.105
970	AGRICULTURE-OPERATING	06.105
971	AGRICULTURE-OPERATING	06.110
972	AGRICULTURE-OPERATING	06.110
973	AGRICULTURE-OPERATING	06.110
974	AGRICULTURE-OPERATING	06.110
975	AGRICULTURE-OPERATING	06.110
976	AGRICULTURE-OPERATING	06.110
977	AGRICULTURE-OPERATING	06.110
978	AGRICULTURE-OPERATING	06.110
979	AGRICULTURE-OPERATING	06.115
980	AGRICULTURE-OPERATING	06.115
981	AGRICULTURE-OPERATING	06.115
982	AGRICULTURE-OPERATING	06.115
983	AGRICULTURE-OPERATING	06.115
984	AGRICULTURE-OPERATING	06.115
985	AGRICULTURE-OPERATING	06.120
986	AGRICULTURE-OPERATING	06.120

Exhibit A

#	Agnecy	Budget Appropriation Line
987	AGRICULTURE-OPERATING	06.120
988	AGRICULTURE-OPERATING	06.125
989	AGRICULTURE-OPERATING	06.125
990	AGRICULTURE-OPERATING	06.130
991	AGRICULTURE-OPERATING	06.135
992	AGRICULTURE-OPERATING	06.135
993	AGRICULTURE-OPERATING	06.135
994	AGRICULTURE-OPERATING	06.135
995	AGRICULTURE-OPERATING	06.135
996	AGRICULTURE-OPERATING	06.135
997	AGRICULTURE-OPERATING	06.135
998	AGRICULTURE-OPERATING	06.140
999	NATURAL RESOURCES-OPER	06.200
1000	NATURAL RESOURCES-OPER	06.200
1001	NATURAL RESOURCES-OPER	06.200
1002	NATURAL RESOURCES-OPER	06.200
1003	NATURAL RESOURCES-OPER	06.200
1004	NATURAL RESOURCES-OPER	06.200
1005	NATURAL RESOURCES-OPER	06.200
1006	NATURAL RESOURCES-OPER	06.200
1007	NATURAL RESOURCES-OPER	06.200
1008	NATURAL RESOURCES-OPER	06.200
1009	NATURAL RESOURCES-OPER	06.201
1010	NATURAL RESOURCES-OPER	06.201
1011	NATURAL RESOURCES-OPER	06.201
1012	NATURAL RESOURCES-OPER	06.225
1013	NATURAL RESOURCES-OPER	06.225
1014	NATURAL RESOURCES-OPER	06.225
1015	NATURAL RESOURCES-OPER	06.225
1016	NATURAL RESOURCES-OPER	06.225
1017	NATURAL RESOURCES-OPER	06.225
1018	NATURAL RESOURCES-OPER	06.225
1019	NATURAL RESOURCES-OPER	06.225
1020	NATURAL RESOURCES-OPER	06.225
1021	NATURAL RESOURCES-OPER	06.225
1022	NATURAL RESOURCES-OPER	06.225
1023	NATURAL RESOURCES-OPER	06.225
1024	NATURAL RESOURCES-OPER	06.225
1025	NATURAL RESOURCES-OPER	06.225
1026	NATURAL RESOURCES-OPER	06.225
1027	NATURAL RESOURCES-OPER	06.225
1028	NATURAL RESOURCES-OPER	06.225
1029	NATURAL RESOURCES-OPER	06.225
1030	NATURAL RESOURCES-OPER	06.225
1031	NATURAL RESOURCES-OPER	06.225
1032	NATURAL RESOURCES-OPER	06.225
1033	NATURAL RESOURCES-OPER	06.225
1034	NATURAL RESOURCES-OPER	06.225
1035	NATURAL RESOURCES-OPER	06.225
1036	NATURAL RESOURCES-OPER	06.225
1037	NATURAL RESOURCES-OPER	06.225
1038	NATURAL RESOURCES-OPER	06.225
1039	NATURAL RESOURCES-OPER	06.225
1040	NATURAL RESOURCES-OPER	06.225
1041	NATURAL RESOURCES-OPER	06.225
1042	NATURAL RESOURCES-OPER	06.225
1043	NATURAL RESOURCES-OPER	06.225
1044	NATURAL RESOURCES-OPER	06.225

Exhibit A

#	Agnecy	Budget Appropriation Line
1045	NATURAL RESOURCES-OPER	06.225
1046	NATURAL RESOURCES-OPER	06.225
1047	NATURAL RESOURCES-OPER	06.225
1048	NATURAL RESOURCES-OPER	06.225
1049	NATURAL RESOURCES-OPER	06.225
1050	NATURAL RESOURCES-OPER	06.225
1051	NATURAL RESOURCES-OPER	06.225
1052	NATURAL RESOURCES-OPER	06.225
1053	NATURAL RESOURCES-OPER	06.225
1054	NATURAL RESOURCES-OPER	06.225
1055	NATURAL RESOURCES-OPER	06.225
1056	NATURAL RESOURCES-OPER	06.225
1057	NATURAL RESOURCES-OPER	06.225
1058	NATURAL RESOURCES-OPER	06.225
1059	NATURAL RESOURCES-OPER	06.225
1060	NATURAL RESOURCES-OPER	06.225
1061	NATURAL RESOURCES-OPER	06.225
1062	NATURAL RESOURCES-OPER	06.225
1063	NATURAL RESOURCES-OPER	06.225
1064	NATURAL RESOURCES-OPER	06.225
1065	NATURAL RESOURCES-OPER	06.225
1066	NATURAL RESOURCES-OPER	06.225
1067	NATURAL RESOURCES-OPER	06.225
1068	NATURAL RESOURCES-OPER	06.225
1069	NATURAL RESOURCES-OPER	06.225
1070	NATURAL RESOURCES-OPER	06.225
1071	NATURAL RESOURCES-OPER	06.225
1072	NATURAL RESOURCES-OPER	06.225
1073	NATURAL RESOURCES-OPER	06.225
1074	NATURAL RESOURCES-OPER	06.225
1075	NATURAL RESOURCES-OPER	06.225
1076	NATURAL RESOURCES-OPER	06.225
1077	NATURAL RESOURCES-OPER	06.225
1078	NATURAL RESOURCES-OPER	06.225
1079	NATURAL RESOURCES-OPER	06.225
1080	NATURAL RESOURCES-OPER	06.225
1081	NATURAL RESOURCES-OPER	06.225
1082	NATURAL RESOURCES-OPER	06.225
1083	NATURAL RESOURCES-OPER	06.225
1084	NATURAL RESOURCES-OPER	06.225
1085	NATURAL RESOURCES-OPER	06.225
1086	NATURAL RESOURCES-OPER	06.225
1087	NATURAL RESOURCES-OPER	06.225
1088	NATURAL RESOURCES-OPER	06.225
1089	NATURAL RESOURCES-OPER	06.225
1090	NATURAL RESOURCES-OPER	06.225
1091	NATURAL RESOURCES-OPER	06.225
1092	NATURAL RESOURCES-OPER	06.225
1093	NATURAL RESOURCES-OPER	06.225
1094	NATURAL RESOURCES-OPER	06.225
1095	NATURAL RESOURCES-OPER	06.225
1096	NATURAL RESOURCES-OPER	06.225
1097	NATURAL RESOURCES-OPER	06.225
1098	NATURAL RESOURCES-OPER	06.225
1099	NATURAL RESOURCES-OPER	06.225
1100	NATURAL RESOURCES-OPER	06.225
1101	NATURAL RESOURCES-OPER	06.225
1102	NATURAL RESOURCES-OPER	06.225

Exhibit A

#	Agnecy	Budget Appropriation Line
1103	NATURAL RESOURCES-OPER	06.225
1104	NATURAL RESOURCES-OPER	06.225
1105	NATURAL RESOURCES-OPER	06.225
1106	NATURAL RESOURCES-OPER	06.225
1107	NATURAL RESOURCES-OPER	06.225
1108	NATURAL RESOURCES-OPER	06.225
1109	NATURAL RESOURCES-OPER	06.225
1110	NATURAL RESOURCES-OPER	06.225
1111	NATURAL RESOURCES-OPER	06.225
1112	NATURAL RESOURCES-OPER	06.225
1113	NATURAL RESOURCES-OPER	06.225
1114	NATURAL RESOURCES-OPER	06.225
1115	NATURAL RESOURCES-OPER	06.225
1116	NATURAL RESOURCES-OPER	06.225
1117	NATURAL RESOURCES-OPER	06.225
1118	NATURAL RESOURCES-OPER	06.225
1119	NATURAL RESOURCES-OPER	06.225
1120	NATURAL RESOURCES-OPER	06.225
1121	NATURAL RESOURCES-OPER	06.225
1122	NATURAL RESOURCES-OPER	06.225
1123	NATURAL RESOURCES-OPER	06.225
1124	NATURAL RESOURCES-OPER	06.225
1125	NATURAL RESOURCES-OPER	06.225
1126	NATURAL RESOURCES-OPER	06.225
1127	NATURAL RESOURCES-OPER	06.225
1128	NATURAL RESOURCES-OPER	06.225
1129	NATURAL RESOURCES-OPER	06.225
1130	NATURAL RESOURCES-OPER	06.225
1131	NATURAL RESOURCES-OPER	06.225
1132	NATURAL RESOURCES-OPER	06.225
1133	NATURAL RESOURCES-OPER	06.225
1134	NATURAL RESOURCES-OPER	06.225
1135	NATURAL RESOURCES-OPER	06.225
1136	NATURAL RESOURCES-OPER	06.225
1137	NATURAL RESOURCES-OPER	06.225
1138	NATURAL RESOURCES-OPER	06.225
1139	NATURAL RESOURCES-OPER	06.225
1140	NATURAL RESOURCES-OPER	06.225
1141	NATURAL RESOURCES-OPER	06.225
1142	NATURAL RESOURCES-OPER	06.230
1143	NATURAL RESOURCES-OPER	06.230
1144	NATURAL RESOURCES-OPER	06.250
1145	NATURAL RESOURCES-OPER	06.250
1146	NATURAL RESOURCES-OPER	06.250
1147	NATURAL RESOURCES-OPER	06.250
1148	NATURAL RESOURCES-OPER	06.250
1149	NATURAL RESOURCES-OPER	06.250
1150	NATURAL RESOURCES-OPER	06.250
1151	NATURAL RESOURCES-OPER	06.250
1152	NATURAL RESOURCES-OPER	06.250
1153	NATURAL RESOURCES-OPER	06.250
1154	NATURAL RESOURCES-OPER	06.250
1155	NATURAL RESOURCES-OPER	06.250
1156	NATURAL RESOURCES-OPER	06.250
1157	NATURAL RESOURCES-OPER	06.250
1158	NATURAL RESOURCES-OPER	06.250
1159	NATURAL RESOURCES-OPER	06.250
1160	NATURAL RESOURCES-OPER	06.250

Exhibit A

#	Agnecy	Budget Appropriation Line
1161	NATURAL RESOURCES-OPER	06.250
1162	NATURAL RESOURCES-OPER	06.250
1163	NATURAL RESOURCES-OPER	06.250
1164	NATURAL RESOURCES-OPER	06.250
1165	NATURAL RESOURCES-OPER	06.250
1166	NATURAL RESOURCES-OPER	06.250
1167	NATURAL RESOURCES-OPER	06.250
1168	NATURAL RESOURCES-OPER	06.250
1169	NATURAL RESOURCES-OPER	06.250
1170	NATURAL RESOURCES-OPER	06.250
1171	NATURAL RESOURCES-OPER	06.250
1172	NATURAL RESOURCES-OPER	06.250
1173	NATURAL RESOURCES-OPER	06.250
1174	NATURAL RESOURCES-OPER	06.250
1175	NATURAL RESOURCES-OPER	06.250
1176	NATURAL RESOURCES-OPER	06.250
1177	NATURAL RESOURCES-OPER	06.250
1178	NATURAL RESOURCES-OPER	06.250
1179	NATURAL RESOURCES-OPER	06.250
1180	NATURAL RESOURCES-OPER	06.250
1181	NATURAL RESOURCES-OPER	06.250
1182	NATURAL RESOURCES-OPER	06.250
1183	NATURAL RESOURCES-OPER	06.250
1184	NATURAL RESOURCES-OPER	06.250
1185	NATURAL RESOURCES-OPER	06.250
1186	NATURAL RESOURCES-OPER	06.255
1187	NATURAL RESOURCES-OPER	06.260
1188	NATURAL RESOURCES-OPER	06.275
1189	NATURAL RESOURCES-OPER	06.275
1190	NATURAL RESOURCES-OPER	06.275
1191	NATURAL RESOURCES-OPER	06.275
1192	NATURAL RESOURCES-OPER	06.275
1193	NATURAL RESOURCES-OPER	06.275
1194	NATURAL RESOURCES-OPER	06.275
1195	NATURAL RESOURCES-OPER	06.275
1196	NATURAL RESOURCES-OPER	06.275
1197	NATURAL RESOURCES-OPER	06.275
1198	NATURAL RESOURCES-OPER	06.275
1199	NATURAL RESOURCES-OPER	06.275
1200	NATURAL RESOURCES-OPER	06.275
1201	NATURAL RESOURCES-OPER	06.275
1202	NATURAL RESOURCES-OPER	06.275
1203	NATURAL RESOURCES-OPER	06.275
1204	NATURAL RESOURCES-OPER	06.275
1205	NATURAL RESOURCES-OPER	06.275
1206	NATURAL RESOURCES-OPER	06.275
1207	NATURAL RESOURCES-OPER	06.275
1208	NATURAL RESOURCES-OPER	06.275
1209	NATURAL RESOURCES-OPER	06.275
1210	NATURAL RESOURCES-OPER	06.280
1211	NATURAL RESOURCES-OPER	06.280
1212	NATURAL RESOURCES-OPER	06.280
1213	NATURAL RESOURCES-OPER	06.280
1214	NATURAL RESOURCES-OPER	06.280
1215	NATURAL RESOURCES-OPER	06.280
1216	NATURAL RESOURCES-OPER	06.280
1217	NATURAL RESOURCES-OPER	06.280
1218	NATURAL RESOURCES-OPER	06.285

Exhibit A

#	Agnecy	Budget Appropriation Line
1219	NATURAL RESOURCES-OPER	06.300
1220	NATURAL RESOURCES-OPER	06.300
1221	NATURAL RESOURCES-OPER	06.300
1222	NATURAL RESOURCES-OPER	06.300
1223	NATURAL RESOURCES-OPER	06.300
1224	NATURAL RESOURCES-OPER	06.300
1225	NATURAL RESOURCES-OPER	06.300
1226	NATURAL RESOURCES-OPER	06.300
1227	NATURAL RESOURCES-OPER	06.300
1228	NATURAL RESOURCES-OPER	06.300
1229	NATURAL RESOURCES-OPER	06.300
1230	NATURAL RESOURCES-OPER	06.300
1231	NATURAL RESOURCES-OPER	06.300
1232	NATURAL RESOURCES-OPER	06.300
1233	NATURAL RESOURCES-OPER	06.300
1234	NATURAL RESOURCES-OPER	06.300
1235	NATURAL RESOURCES-OPER	06.300
1236	NATURAL RESOURCES-OPER	06.300
1237	NATURAL RESOURCES-OPER	06.325
1238	NATURAL RESOURCES-OPER	06.325
1239	NATURAL RESOURCES-OPER	06.330
1240	NATURAL RESOURCES-OPER	06.335
1241	NATURAL RESOURCES-OPER	06.335
1242	NATURAL RESOURCES-OPER	06.340
1243	NATURAL RESOURCES-OPER	06.340
1244	NATURAL RESOURCES-OPER	06.345
1245	NATURAL RESOURCES-OPER	06.350
1246	NATURAL RESOURCES-OPER	06.355
1247	NATURAL RESOURCES-OPER	06.355
1248	NATURAL RESOURCES-OPER	06.360
1249	NATURAL RESOURCES-OPER	06.360
1250	NATURAL RESOURCES-OPER	06.360
1251	NATURAL RESOURCES-OPER	06.360
1252	NATURAL RESOURCES-OPER	06.365
1253	CONSERVATION-OPERATING	06.600
1254	CONSERVATION-OPERATING	06.600
1255	CONSERVATION-OPERATING	06.601
1256	CONSERVATION-OPERATING	06.601
1257	CONSERVATION-OPERATING	06.601
1258	CONSERVATION-OPERATING	06.602
1259	CONSERVATION-OPERATING	06.605
1260	CONSERVATION-OPERATING	06.605
1261	CONSERVATION-OPERATING	06.610
1262	CONSERVATION-OPERATING	06.610
1263	CONSERVATION-OPERATING	06.610
1264	CONSERVATION-OPERATING	06.615
1265	CONSERVATION-OPERATING	06.615
1266	CONSERVATION-OPERATING	06.620
1267	CONSERVATION-OPERATING	06.620
1268	CONSERVATION-OPERATING	06.625
1269	CONSERVATION-OPERATING	06.625
1270	CONSERVATION-OPERATING	06.630
1271	CONSERVATION-OPERATING	06.630
1272	CONSERVATION-OPERATING	06.635
1273	CONSERVATION-OPERATING	06.635
1274	CONSERVATION-OPERATING	06.640
1275	CONSERVATION-OPERATING	06.640
1276	CONSERVATION-OPERATING	06.641

Exhibit A

#	Agnecy	Budget Appropriation Line
1277	CONSERVATION-OPERATING	06.645
1278	CONSERVATION-OPERATING	06.645
1279	CONSERVATION-OPERATING	06.645
1280	CONSERVATION-OPERATING	06.650
1281	CONSERVATION-OPERATING	06.650
1282	ECONOMIC DEVELOP-OPER	07.005
1283	ECONOMIC DEVELOP-OPER	07.005
1284	ECONOMIC DEVELOP-OPER	07.005
1285	ECONOMIC DEVELOP-OPER	07.005
1286	ECONOMIC DEVELOP-OPER	07.005
1287	ECONOMIC DEVELOP-OPER	07.005
1288	ECONOMIC DEVELOP-OPER	07.005
1289	ECONOMIC DEVELOP-OPER	07.006
1290	ECONOMIC DEVELOP-OPER	07.006
1291	ECONOMIC DEVELOP-OPER	07.006
1292	ECONOMIC DEVELOP-OPER	07.010
1293	ECONOMIC DEVELOP-OPER	07.010
1294	ECONOMIC DEVELOP-OPER	07.010
1295	ECONOMIC DEVELOP-OPER	07.010
1296	ECONOMIC DEVELOP-OPER	07.010
1297	ECONOMIC DEVELOP-OPER	07.010
1298	ECONOMIC DEVELOP-OPER	07.010
1299	ECONOMIC DEVELOP-OPER	07.010
1300	ECONOMIC DEVELOP-OPER	07.010
1301	ECONOMIC DEVELOP-OPER	07.010
1302	ECONOMIC DEVELOP-OPER	07.010
1303	ECONOMIC DEVELOP-OPER	07.015
1304	ECONOMIC DEVELOP-OPER	07.020
1305	ECONOMIC DEVELOP-OPER	07.025
1306	ECONOMIC DEVELOP-OPER	07.025
1307	ECONOMIC DEVELOP-OPER	07.030
1308	ECONOMIC DEVELOP-OPER	07.030
1309	ECONOMIC DEVELOP-OPER	07.035
1310	ECONOMIC DEVELOP-OPER	07.036
1311	ECONOMIC DEVELOP-OPER	07.040
1312	ECONOMIC DEVELOP-OPER	07.045
1313	ECONOMIC DEVELOP-OPER	07.050
1314	ECONOMIC DEVELOP-OPER	07.055
1315	ECONOMIC DEVELOP-OPER	07.060
1316	ECONOMIC DEVELOP-OPER	07.065
1317	ECONOMIC DEVELOP-OPER	07.070
1318	ECONOMIC DEVELOP-OPER	07.070
1319	ECONOMIC DEVELOP-OPER	07.070
1320	ECONOMIC DEVELOP-OPER	07.075
1321	ECONOMIC DEVELOP-OPER	07.075
1322	ECONOMIC DEVELOP-OPER	07.075
1323	ECONOMIC DEVELOP-OPER	07.075
1324	ECONOMIC DEVELOP-OPER	07.075
1325	ECONOMIC DEVELOP-OPER	07.080
1326	ECONOMIC DEVELOP-OPER	07.080
1327	ECONOMIC DEVELOP-OPER	07.085
1328	ECONOMIC DEVELOP-OPER	07.090
1329	ECONOMIC DEVELOP-OPER	07.095
1330	ECONOMIC DEVELOP-OPER	07.100
1331	ECONOMIC DEVELOP-OPER	07.100
1332	ECONOMIC DEVELOP-OPER	07.100
1333	ECONOMIC DEVELOP-OPER	07.100
1334	ECONOMIC DEVELOP-OPER	07.100

Exhibit A

#	Agnecy	Budget Appropriation Line
1335	ECONOMIC DEVELOP-OPER	07.105
1336	ECONOMIC DEVELOP-OPER	07.110
1337	ECONOMIC DEVELOP-OPER	07.110
1338	ECONOMIC DEVELOP-OPER	07.111
1339	ECONOMIC DEVELOP-OPER	07.115
1340	ECONOMIC DEVELOP-OPER	07.115
1341	ECONOMIC DEVELOP-OPER	07.115
1342	ECONOMIC DEVELOP-OPER	07.115
1343	ECONOMIC DEVELOP-OPER	07.115
1344	ECONOMIC DEVELOP-OPER	07.115
1345	ECONOMIC DEVELOP-OPER	07.115
1346	ECONOMIC DEVELOP-OPER	07.120
1347	ECONOMIC DEVELOP-OPER	07.125
1348	ECONOMIC DEVELOP-OPER	07.126
1349	ECONOMIC DEVELOP-OPER	07.130
1350	ECONOMIC DEVELOP-OPER	07.135
1351	ECONOMIC DEVELOP-OPER	07.135
1352	ECONOMIC DEVELOP-OPER	07.135
1353	ECONOMIC DEVELOP-OPER	07.135
1354	ECONOMIC DEVELOP-OPER	07.135
1355	ECONOMIC DEVELOP-OPER	07.135
1356	ECONOMIC DEVELOP-OPER	07.135
1357	ECONOMIC DEVELOP-OPER	07.140
1358	ECONOMIC DEVELOP-OPER	07.145
1359	DCI-OPERATING	07.400
1360	DCI-OPERATING	07.400
1361	DCI-OPERATING	07.401
1362	DCI-OPERATING	07.405
1363	DCI-OPERATING	07.405
1364	DCI-OPERATING	07.405
1365	DCI-OPERATING	07.405
1366	DCI-OPERATING	07.405
1367	DCI-OPERATING	07.405
1368	DCI-OPERATING	07.405
1369	DCI-OPERATING	07.410
1370	DCI-OPERATING	07.410
1371	DCI-OPERATING	07.410
1372	DCI-OPERATING	07.415
1373	DCI-OPERATING	07.415
1374	DCI-OPERATING	07.420
1375	DCI-OPERATING	07.420
1376	DCI-OPERATING	07.425
1377	DCI-OPERATING	07.425
1378	DCI-OPERATING	07.430
1379	DCI-OPERATING	07.430
1380	DCI-OPERATING	07.435
1381	DCI-OPERATING	07.435
1382	DCI-OPERATING	07.435
1383	DCI-OPERATING	07.435
1384	DCI-OPERATING	07.440
1385	DCI-OPERATING	07.445
1386	DCI-OPERATING	07.450
1387	DCI-OPERATING	07.455
1388	DCI-OPERATING	07.455
1389	DCI-OPERATING	07.455
1390	DCI-OPERATING	07.455
1391	DCI-OPERATING	07.455
1392	DCI-OPERATING	07.460

Exhibit A

#	Agnecy	Budget Appropriation Line
1393	DCI-OPERATING	07.460
1394	DCI-OPERATING	07.465
1395	DCI-OPERATING	07.465
1396	DCI-OPERATING	07.470
1397	DCI-OPERATING	07.475
1398	DCI-OPERATING	07.475
1399	DCI-OPERATING	07.480
1400	DCI-OPERATING	07.480
1401	DCI-OPERATING	07.485
1402	DCI-OPERATING	07.490
1403	DCI-OPERATING	07.490
1404	DCI-OPERATING	07.495
1405	DCI-OPERATING	07.495
1406	DCI-OPERATING	07.495
1407	DCI-OPERATING	07.500
1408	DCI-OPERATING	07.505
1409	DCI-OPERATING	07.505
1410	DCI-OPERATING	07.505
1411	DCI-OPERATING	07.510
1412	DCI-OPERATING	07.515
1413	DCI-OPERATING	07.515
1414	DCI-OPERATING	07.520
1415	DCI-OPERATING	07.520
1416	DCI-OPERATING	07.525
1417	DCI-OPERATING	07.530
1418	DCI-OPERATING	07.535
1419	DCI-OPERATING	07.540
1420	DCI-OPERATING	07.545
1421	DCI-OPERATING	07.545
1422	DCI-OPERATING	07.545
1423	DCI-OPERATING	07.545
1424	DCI-OPERATING	07.545
1425	DCI-OPERATING	07.550
1426	DCI-OPERATING	07.555
1427	DCI-OPERATING	07.555
1428	DCI-OPERATING	07.560
1429	DCI-OPERATING	07.560
1430	DCI-OPERATING	07.560
1431	DCI-OPERATING	07.560
1432	LABOR & INDUSTRIAL REL-OPER	07.800
1433	LABOR & INDUSTRIAL REL-OPER	07.800
1434	LABOR & INDUSTRIAL REL-OPER	07.800
1435	LABOR & INDUSTRIAL REL-OPER	07.800
1436	LABOR & INDUSTRIAL REL-OPER	07.801
1437	LABOR & INDUSTRIAL REL-OPER	07.801
1438	LABOR & INDUSTRIAL REL-OPER	07.801
1439	LABOR & INDUSTRIAL REL-OPER	07.805
1440	LABOR & INDUSTRIAL REL-OPER	07.805
1441	LABOR & INDUSTRIAL REL-OPER	07.805
1442	LABOR & INDUSTRIAL REL-OPER	07.805
1443	LABOR & INDUSTRIAL REL-OPER	07.810
1444	LABOR & INDUSTRIAL REL-OPER	07.810
1445	LABOR & INDUSTRIAL REL-OPER	07.810
1446	LABOR & INDUSTRIAL REL-OPER	07.810
1447	LABOR & INDUSTRIAL REL-OPER	07.810
1448	LABOR & INDUSTRIAL REL-OPER	07.815
1449	LABOR & INDUSTRIAL REL-OPER	07.815
1450	LABOR & INDUSTRIAL REL-OPER	07.815

Exhibit A

#	Agnecy	Budget Appropriation Line
1451	LABOR & INDUSTRIAL REL-OPER	07.815
1452	LABOR & INDUSTRIAL REL-OPER	07.815
1453	LABOR & INDUSTRIAL REL-OPER	07.815
1454	LABOR & INDUSTRIAL REL-OPER	07.820
1455	LABOR & INDUSTRIAL REL-OPER	07.820
1456	LABOR & INDUSTRIAL REL-OPER	07.820
1457	LABOR & INDUSTRIAL REL-OPER	07.820
1458	LABOR & INDUSTRIAL REL-OPER	07.820
1459	LABOR & INDUSTRIAL REL-OPER	07.820
1460	LABOR & INDUSTRIAL REL-OPER	07.820
1461	LABOR & INDUSTRIAL REL-OPER	07.820
1462	LABOR & INDUSTRIAL REL-OPER	07.820
1463	LABOR & INDUSTRIAL REL-OPER	07.825
1464	LABOR & INDUSTRIAL REL-OPER	07.825
1465	LABOR & INDUSTRIAL REL-OPER	07.825
1466	LABOR & INDUSTRIAL REL-OPER	07.825
1467	LABOR & INDUSTRIAL REL-OPER	07.830
1468	LABOR & INDUSTRIAL REL-OPER	07.830
1469	LABOR & INDUSTRIAL REL-OPER	07.830
1470	LABOR & INDUSTRIAL REL-OPER	07.830
1471	LABOR & INDUSTRIAL REL-OPER	07.830
1472	LABOR & INDUSTRIAL REL-OPER	07.830
1473	LABOR & INDUSTRIAL REL-OPER	07.830
1474	LABOR & INDUSTRIAL REL-OPER	07.830
1475	LABOR & INDUSTRIAL REL-OPER	07.835
1476	LABOR & INDUSTRIAL REL-OPER	07.835
1477	LABOR & INDUSTRIAL REL-OPER	07.840
1478	LABOR & INDUSTRIAL REL-OPER	07.840
1479	LABOR & INDUSTRIAL REL-OPER	07.840
1480	LABOR & INDUSTRIAL REL-OPER	07.840
1481	LABOR & INDUSTRIAL REL-OPER	07.840
1482	LABOR & INDUSTRIAL REL-OPER	07.845
1483	LABOR & INDUSTRIAL REL-OPER	07.850
1484	LABOR & INDUSTRIAL REL-OPER	07.855
1485	LABOR & INDUSTRIAL REL-OPER	07.860
1486	LABOR & INDUSTRIAL REL-OPER	07.865
1487	LABOR & INDUSTRIAL REL-OPER	07.870
1488	LABOR & INDUSTRIAL REL-OPER	07.875
1489	LABOR & INDUSTRIAL REL-OPER	07.880
1490	LABOR & INDUSTRIAL REL-OPER	07.880
1491	LABOR & INDUSTRIAL REL-OPER	07.880
1492	LABOR & INDUSTRIAL REL-OPER	07.880
1493	LABOR & INDUSTRIAL REL-OPER	07.885
1494	LABOR & INDUSTRIAL REL-OPER	07.890
1495	LABOR & INDUSTRIAL REL-OPER	07.890
1496	LABOR & INDUSTRIAL REL-OPER	07.895
1497	LABOR & INDUSTRIAL REL-OPER	07.895
1498	LABOR & INDUSTRIAL REL-OPER	07.900
1499	LABOR & INDUSTRIAL REL-OPER	07.905
1500	LABOR & INDUSTRIAL REL-OPER	07.905
1501	LABOR & INDUSTRIAL REL-OPER	07.905
1502	LABOR & INDUSTRIAL REL-OPER	07.905
1503	LABOR & INDUSTRIAL REL-OPER	07.905
1504	LABOR & INDUSTRIAL REL-OPER	07.905
1505	LABOR & INDUSTRIAL REL-OPER	07.910
1506	PUBLIC SAFETY-OPERATING	08.005
1507	PUBLIC SAFETY-OPERATING	08.005
1508	PUBLIC SAFETY-OPERATING	08.005

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#	Agnecy	Budget Appropriation Line
1509	PUBLIC SAFETY-OPERATING	08.005
1510	PUBLIC SAFETY-OPERATING	08.005
1511	PUBLIC SAFETY-OPERATING	08.005
1512	PUBLIC SAFETY-OPERATING	08.005
1513	PUBLIC SAFETY-OPERATING	08.005
1514	PUBLIC SAFETY-OPERATING	08.005
1515	PUBLIC SAFETY-OPERATING	08.005
1516	PUBLIC SAFETY-OPERATING	08.005
1517	PUBLIC SAFETY-OPERATING	08.005
1518	PUBLIC SAFETY-OPERATING	08.005
1519	PUBLIC SAFETY-OPERATING	08.005
1520	PUBLIC SAFETY-OPERATING	08.005
1521	PUBLIC SAFETY-OPERATING	08.005
1522	PUBLIC SAFETY-OPERATING	08.005
1523	PUBLIC SAFETY-OPERATING	08.005
1524	PUBLIC SAFETY-OPERATING	08.005
1525	PUBLIC SAFETY-OPERATING	08.005
1526	PUBLIC SAFETY-OPERATING	08.005
1527	PUBLIC SAFETY-OPERATING	08.006
1528	PUBLIC SAFETY-OPERATING	08.006
1529	PUBLIC SAFETY-OPERATING	08.006
1530	PUBLIC SAFETY-OPERATING	08.010
1531	PUBLIC SAFETY-OPERATING	08.015
1532	PUBLIC SAFETY-OPERATING	08.020
1533	PUBLIC SAFETY-OPERATING	08.025
1534	PUBLIC SAFETY-OPERATING	08.025
1535	PUBLIC SAFETY-OPERATING	08.025
1536	PUBLIC SAFETY-OPERATING	08.030
1537	PUBLIC SAFETY-OPERATING	08.035
1538	PUBLIC SAFETY-OPERATING	08.040
1539	PUBLIC SAFETY-OPERATING	08.040
1540	PUBLIC SAFETY-OPERATING	08.045
1541	PUBLIC SAFETY-OPERATING	08.045
1542	PUBLIC SAFETY-OPERATING	08.045
1543	PUBLIC SAFETY-OPERATING	08.045
1544	PUBLIC SAFETY-OPERATING	08.045
1545	PUBLIC SAFETY-OPERATING	08.045
1546	PUBLIC SAFETY-OPERATING	08.045
1547	PUBLIC SAFETY-OPERATING	08.050
1548	PUBLIC SAFETY-OPERATING	08.055
1549	PUBLIC SAFETY-OPERATING	08.060
1550	PUBLIC SAFETY-OPERATING	08.065
1551	PUBLIC SAFETY-OPERATING	08.070
1552	PUBLIC SAFETY-OPERATING	08.070
1553	PUBLIC SAFETY-OPERATING	08.075
1554	PUBLIC SAFETY-OPERATING	08.075
1555	PUBLIC SAFETY-OPERATING	08.075
1556	PUBLIC SAFETY-OPERATING	08.075
1557	PUBLIC SAFETY-OPERATING	08.075
1558	PUBLIC SAFETY-OPERATING	08.075
1559	PUBLIC SAFETY-OPERATING	08.075
1560	PUBLIC SAFETY-OPERATING	08.075
1561	PUBLIC SAFETY-OPERATING	08.075
1562	PUBLIC SAFETY-OPERATING	08.080
1563	PUBLIC SAFETY-OPERATING	08.080
1564	PUBLIC SAFETY-OPERATING	08.080
1565	PUBLIC SAFETY-OPERATING	08.080
1566	PUBLIC SAFETY-OPERATING	08.080

Exhibit A

#	Agnecy	Budget Appropriation Line
1567	PUBLIC SAFETY-OPERATING	08.080
1568	PUBLIC SAFETY-OPERATING	08.080
1569	PUBLIC SAFETY-OPERATING	08.080
1570	PUBLIC SAFETY-OPERATING	08.080
1571	PUBLIC SAFETY-OPERATING	08.080
1572	PUBLIC SAFETY-OPERATING	08.080
1573	PUBLIC SAFETY-OPERATING	08.080
1574	PUBLIC SAFETY-OPERATING	08.080
1575	PUBLIC SAFETY-OPERATING	08.080
1576	PUBLIC SAFETY-OPERATING	08.080
1577	PUBLIC SAFETY-OPERATING	08.080
1578	PUBLIC SAFETY-OPERATING	08.080
1579	PUBLIC SAFETY-OPERATING	08.080
1580	PUBLIC SAFETY-OPERATING	08.080
1581	PUBLIC SAFETY-OPERATING	08.080
1582	PUBLIC SAFETY-OPERATING	08.085
1583	PUBLIC SAFETY-OPERATING	08.085
1584	PUBLIC SAFETY-OPERATING	08.085
1585	PUBLIC SAFETY-OPERATING	08.085
1586	PUBLIC SAFETY-OPERATING	08.085
1587	PUBLIC SAFETY-OPERATING	08.085
1588	PUBLIC SAFETY-OPERATING	08.085
1589	PUBLIC SAFETY-OPERATING	08.085
1590	PUBLIC SAFETY-OPERATING	08.085
1591	PUBLIC SAFETY-OPERATING	08.085
1592	PUBLIC SAFETY-OPERATING	08.085
1593	PUBLIC SAFETY-OPERATING	08.085
1594	PUBLIC SAFETY-OPERATING	08.085
1595	PUBLIC SAFETY-OPERATING	08.085
1596	PUBLIC SAFETY-OPERATING	08.085
1597	PUBLIC SAFETY-OPERATING	08.085
1598	PUBLIC SAFETY-OPERATING	08.085
1599	PUBLIC SAFETY-OPERATING	08.085
1600	PUBLIC SAFETY-OPERATING	08.085
1601	PUBLIC SAFETY-OPERATING	08.090
1602	PUBLIC SAFETY-OPERATING	08.090
1603	PUBLIC SAFETY-OPERATING	08.090
1604	PUBLIC SAFETY-OPERATING	08.090
1605	PUBLIC SAFETY-OPERATING	08.090
1606	PUBLIC SAFETY-OPERATING	08.090
1607	PUBLIC SAFETY-OPERATING	08.090
1608	PUBLIC SAFETY-OPERATING	08.095
1609	PUBLIC SAFETY-OPERATING	08.095
1610	PUBLIC SAFETY-OPERATING	08.095
1611	PUBLIC SAFETY-OPERATING	08.100
1612	PUBLIC SAFETY-OPERATING	08.100
1613	PUBLIC SAFETY-OPERATING	08.100
1614	PUBLIC SAFETY-OPERATING	08.100
1615	PUBLIC SAFETY-OPERATING	08.105
1616	PUBLIC SAFETY-OPERATING	08.105
1617	PUBLIC SAFETY-OPERATING	08.105
1618	PUBLIC SAFETY-OPERATING	08.105
1619	PUBLIC SAFETY-OPERATING	08.105
1620	PUBLIC SAFETY-OPERATING	08.105
1621	PUBLIC SAFETY-OPERATING	08.105
1622	PUBLIC SAFETY-OPERATING	08.105
1623	PUBLIC SAFETY-OPERATING	08.105
1624	PUBLIC SAFETY-OPERATING	08.105

Exhibit A

#	Agnecy	Budget Appropriation Line
1625	PUBLIC SAFETY-OPERATING	08.105
1626	PUBLIC SAFETY-OPERATING	08.110
1627	PUBLIC SAFETY-OPERATING	08.110
1628	PUBLIC SAFETY-OPERATING	08.110
1629	PUBLIC SAFETY-OPERATING	08.110
1630	PUBLIC SAFETY-OPERATING	08.110
1631	PUBLIC SAFETY-OPERATING	08.110
1632	PUBLIC SAFETY-OPERATING	08.110
1633	PUBLIC SAFETY-OPERATING	08.110
1634	PUBLIC SAFETY-OPERATING	08.115
1635	PUBLIC SAFETY-OPERATING	08.115
1636	PUBLIC SAFETY-OPERATING	08.115
1637	PUBLIC SAFETY-OPERATING	08.115
1638	PUBLIC SAFETY-OPERATING	08.115
1639	PUBLIC SAFETY-OPERATING	08.120
1640	PUBLIC SAFETY-OPERATING	08.125
1641	PUBLIC SAFETY-OPERATING	08.125
1642	PUBLIC SAFETY-OPERATING	08.125
1643	PUBLIC SAFETY-OPERATING	08.125
1644	PUBLIC SAFETY-OPERATING	08.125
1645	PUBLIC SAFETY-OPERATING	08.125
1646	PUBLIC SAFETY-OPERATING	08.125
1647	PUBLIC SAFETY-OPERATING	08.125
1648	PUBLIC SAFETY-OPERATING	08.125
1649	PUBLIC SAFETY-OPERATING	08.125
1650	PUBLIC SAFETY-OPERATING	08.125
1651	PUBLIC SAFETY-OPERATING	08.125
1652	PUBLIC SAFETY-OPERATING	08.125
1653	PUBLIC SAFETY-OPERATING	08.125
1654	PUBLIC SAFETY-OPERATING	08.125
1655	PUBLIC SAFETY-OPERATING	08.130
1656	PUBLIC SAFETY-OPERATING	08.135
1657	PUBLIC SAFETY-OPERATING	08.140
1658	PUBLIC SAFETY-OPERATING	08.140
1659	PUBLIC SAFETY-OPERATING	08.140
1660	PUBLIC SAFETY-OPERATING	08.140
1661	PUBLIC SAFETY-OPERATING	08.150
1662	PUBLIC SAFETY-OPERATING	08.150
1663	PUBLIC SAFETY-OPERATING	08.150
1664	PUBLIC SAFETY-OPERATING	08.150
1665	PUBLIC SAFETY-OPERATING	08.150
1666	PUBLIC SAFETY-OPERATING	08.150
1667	PUBLIC SAFETY-OPERATING	08.150
1668	PUBLIC SAFETY-OPERATING	08.150
1669	PUBLIC SAFETY-OPERATING	08.155
1670	PUBLIC SAFETY-OPERATING	08.155
1671	PUBLIC SAFETY-OPERATING	08.160
1672	PUBLIC SAFETY-OPERATING	08.160
1673	PUBLIC SAFETY-OPERATING	08.160
1674	PUBLIC SAFETY-OPERATING	08.160
1675	PUBLIC SAFETY-OPERATING	08.165
1676	PUBLIC SAFETY-OPERATING	08.165
1677	PUBLIC SAFETY-OPERATING	08.165
1678	PUBLIC SAFETY-OPERATING	08.170
1679	PUBLIC SAFETY-OPERATING	08.175
1680	PUBLIC SAFETY-OPERATING	08.180
1681	PUBLIC SAFETY-OPERATING	08.180
1682	PUBLIC SAFETY-OPERATING	08.180

Exhibit A

#	Agnecy	Budget Appropriation Line
1683	PUBLIC SAFETY-OPERATING	08.180
1684	PUBLIC SAFETY-OPERATING	08.180
1685	PUBLIC SAFETY-OPERATING	08.180
1686	PUBLIC SAFETY-OPERATING	08.185
1687	PUBLIC SAFETY-OPERATING	08.190
1688	PUBLIC SAFETY-OPERATING	08.195
1689	PUBLIC SAFETY-OPERATING	08.195
1690	PUBLIC SAFETY-OPERATING	08.195
1691	PUBLIC SAFETY-OPERATING	08.200
1692	PUBLIC SAFETY-OPERATING	08.200
1693	PUBLIC SAFETY-OPERATING	08.205
1694	PUBLIC SAFETY-OPERATING	08.210
1695	PUBLIC SAFETY-OPERATING	08.215
1696	PUBLIC SAFETY-OPERATING	08.220
1697	PUBLIC SAFETY-OPERATING	08.225
1698	PUBLIC SAFETY-OPERATING	08.230
1699	PUBLIC SAFETY-OPERATING	08.235
1700	PUBLIC SAFETY-OPERATING	08.240
1701	PUBLIC SAFETY-OPERATING	08.245
1702	PUBLIC SAFETY-OPERATING	08.245
1703	PUBLIC SAFETY-OPERATING	08.245
1704	PUBLIC SAFETY-OPERATING	08.245
1705	PUBLIC SAFETY-OPERATING	08.250
1706	PUBLIC SAFETY-OPERATING	08.250
1707	PUBLIC SAFETY-OPERATING	08.250
1708	PUBLIC SAFETY-OPERATING	08.250
1709	PUBLIC SAFETY-OPERATING	08.250
1710	PUBLIC SAFETY-OPERATING	08.255
1711	PUBLIC SAFETY-OPERATING	08.260
1712	PUBLIC SAFETY-OPERATING	08.260
1713	PUBLIC SAFETY-OPERATING	08.265
1714	PUBLIC SAFETY-OPERATING	08.265
1715	PUBLIC SAFETY-OPERATING	08.265
1716	PUBLIC SAFETY-OPERATING	08.265
1717	PUBLIC SAFETY-OPERATING	08.270
1718	PUBLIC SAFETY-OPERATING	08.275
1719	PUBLIC SAFETY-OPERATING	08.275
1720	PUBLIC SAFETY-OPERATING	08.280
1721	PUBLIC SAFETY-OPERATING	08.285
1722	PUBLIC SAFETY-OPERATING	08.285
1723	PUBLIC SAFETY-OPERATING	08.285
1724	PUBLIC SAFETY-OPERATING	08.285
1725	PUBLIC SAFETY-OPERATING	08.285
1726	PUBLIC SAFETY-OPERATING	08.285
1727	PUBLIC SAFETY-OPERATING	08.285
1728	PUBLIC SAFETY-OPERATING	08.290
1729	PUBLIC SAFETY-OPERATING	08.295
1730	PUBLIC SAFETY-OPERATING	08.295
1731	PUBLIC SAFETY-OPERATING	08.295
1732	PUBLIC SAFETY-OPERATING	08.295
1733	PUBLIC SAFETY-OPERATING	08.295
1734	PUBLIC SAFETY-OPERATING	08.295
1735	PUBLIC SAFETY-OPERATING	08.295
1736	PUBLIC SAFETY-OPERATING	08.295
1737	PUBLIC SAFETY-OPERATING	08.295
1738	PUBLIC SAFETY-OPERATING	08.295
1739	PUBLIC SAFETY-OPERATING	08.300
1740	PUBLIC SAFETY-OPERATING	08.305

Exhibit A

#	Agnecy	Budget Appropriation Line
1741	PUBLIC SAFETY-OPERATING	08.305
1742	PUBLIC SAFETY-OPERATING	08.310
1743	PUBLIC SAFETY-OPERATING	08.310
1744	PUBLIC SAFETY-OPERATING	08.310
1745	PUBLIC SAFETY-OPERATING	08.310
1746	PUBLIC SAFETY-OPERATING	08.310
1747	PUBLIC SAFETY-OPERATING	08.315
1748	CORRECTIONS-OPERATING	09.005
1749	CORRECTIONS-OPERATING	09.005
1750	CORRECTIONS-OPERATING	09.005
1751	CORRECTIONS-OPERATING	09.005
1752	CORRECTIONS-OPERATING	09.005
1753	CORRECTIONS-OPERATING	09.005
1754	CORRECTIONS-OPERATING	09.005
1755	CORRECTIONS-OPERATING	09.005
1756	CORRECTIONS-OPERATING	09.006
1757	CORRECTIONS-OPERATING	09.006
1758	CORRECTIONS-OPERATING	09.006
1759	CORRECTIONS-OPERATING	09.010
1760	CORRECTIONS-OPERATING	09.010
1761	CORRECTIONS-OPERATING	09.015
1762	CORRECTIONS-OPERATING	09.015
1763	CORRECTIONS-OPERATING	09.015
1764	CORRECTIONS-OPERATING	09.020
1765	CORRECTIONS-OPERATING	09.020
1766	CORRECTIONS-OPERATING	09.020
1767	CORRECTIONS-OPERATING	09.025
1768	CORRECTIONS-OPERATING	09.030
1769	CORRECTIONS-OPERATING	09.030
1770	CORRECTIONS-OPERATING	09.035
1771	CORRECTIONS-OPERATING	09.040
1772	CORRECTIONS-OPERATING	09.045
1773	CORRECTIONS-OPERATING	09.045
1774	CORRECTIONS-OPERATING	09.050
1775	CORRECTIONS-OPERATING	09.055
1776	CORRECTIONS-OPERATING	09.055
1777	CORRECTIONS-OPERATING	09.060
1778	CORRECTIONS-OPERATING	09.065
1779	CORRECTIONS-OPERATING	09.070
1780	CORRECTIONS-OPERATING	09.075
1781	CORRECTIONS-OPERATING	09.080
1782	CORRECTIONS-OPERATING	09.080
1783	CORRECTIONS-OPERATING	09.080
1784	CORRECTIONS-OPERATING	09.080
1785	CORRECTIONS-OPERATING	09.080
1786	CORRECTIONS-OPERATING	09.080
1787	CORRECTIONS-OPERATING	09.085
1788	CORRECTIONS-OPERATING	09.085
1789	CORRECTIONS-OPERATING	09.085
1790	CORRECTIONS-OPERATING	09.085
1791	CORRECTIONS-OPERATING	09.085
1792	CORRECTIONS-OPERATING	09.085
1793	CORRECTIONS-OPERATING	09.085
1794	CORRECTIONS-OPERATING	09.085
1795	CORRECTIONS-OPERATING	09.085
1796	CORRECTIONS-OPERATING	09.090
1797	CORRECTIONS-OPERATING	09.090
1798	CORRECTIONS-OPERATING	09.095

Exhibit A

#	Agnecy	Budget Appropriation Line
1799	CORRECTIONS-OPERATING	09.095
1800	CORRECTIONS-OPERATING	09.100
1801	CORRECTIONS-OPERATING	09.100
1802	CORRECTIONS-OPERATING	09.100
1803	CORRECTIONS-OPERATING	09.105
1804	CORRECTIONS-OPERATING	09.105
1805	CORRECTIONS-OPERATING	09.105
1806	CORRECTIONS-OPERATING	09.110
1807	CORRECTIONS-OPERATING	09.110
1808	CORRECTIONS-OPERATING	09.115
1809	CORRECTIONS-OPERATING	09.115
1810	CORRECTIONS-OPERATING	09.115
1811	CORRECTIONS-OPERATING	09.120
1812	CORRECTIONS-OPERATING	09.120
1813	CORRECTIONS-OPERATING	09.125
1814	CORRECTIONS-OPERATING	09.125
1815	CORRECTIONS-OPERATING	09.130
1816	CORRECTIONS-OPERATING	09.130
1817	CORRECTIONS-OPERATING	09.130
1818	CORRECTIONS-OPERATING	09.135
1819	CORRECTIONS-OPERATING	09.135
1820	CORRECTIONS-OPERATING	09.140
1821	CORRECTIONS-OPERATING	09.140
1822	CORRECTIONS-OPERATING	09.140
1823	CORRECTIONS-OPERATING	09.145
1824	CORRECTIONS-OPERATING	09.145
1825	CORRECTIONS-OPERATING	09.150
1826	CORRECTIONS-OPERATING	09.150
1827	CORRECTIONS-OPERATING	09.150
1828	CORRECTIONS-OPERATING	09.155
1829	CORRECTIONS-OPERATING	09.155
1830	CORRECTIONS-OPERATING	09.160
1831	CORRECTIONS-OPERATING	09.160
1832	CORRECTIONS-OPERATING	09.160
1833	CORRECTIONS-OPERATING	09.165
1834	CORRECTIONS-OPERATING	09.165
1835	CORRECTIONS-OPERATING	09.170
1836	CORRECTIONS-OPERATING	09.170
1837	CORRECTIONS-OPERATING	09.175
1838	CORRECTIONS-OPERATING	09.180
1839	CORRECTIONS-OPERATING	09.180
1840	CORRECTIONS-OPERATING	09.185
1841	CORRECTIONS-OPERATING	09.185
1842	CORRECTIONS-OPERATING	09.185
1843	CORRECTIONS-OPERATING	09.190
1844	CORRECTIONS-OPERATING	09.190
1845	CORRECTIONS-OPERATING	09.190
1846	CORRECTIONS-OPERATING	09.195
1847	CORRECTIONS-OPERATING	09.195
1848	CORRECTIONS-OPERATING	09.195
1849	CORRECTIONS-OPERATING	09.200
1850	CORRECTIONS-OPERATING	09.200
1851	CORRECTIONS-OPERATING	09.200
1852	CORRECTIONS-OPERATING	09.205
1853	CORRECTIONS OPERATING	09.205
1854	CORRECTIONS-OPERATING	09.215
1855	CORRECTIONS-OPERATING	09.220
1856	CORRECTIONS-OPERATING	09.220

Exhibit A

#	Agnecy	Budget Appropriation Line
1857	CORRECTIONS-OPERATING	09.220
1858	CORRECTIONS-OPERATING	09.225
1859	CORRECTIONS-OPERATING	09.230
1860	CORRECTIONS-OPERATING	09.230
1861	CORRECTIONS-OPERATING	09.230
1862	CORRECTIONS-OPERATING	09.235
1863	CORRECTIONS-OPERATING	09.235
1864	CORRECTIONS-OPERATING	09.235
1865	CORRECTIONS-OPERATING	09.235
1866	CORRECTIONS-OPERATING	09.235
1867	CORRECTIONS-OPERATING	09.240
1868	CORRECTIONS-OPERATING	09.240
1869	CORRECTIONS-OPERATING	09.240
1870	CORRECTIONS-OPERATING	09.240
1871	CORRECTIONS-OPERATING	09.245
1872	CORRECTIONS-OPERATING	09.250
1873	CORRECTIONS-OPERATING	09.250
1874	CORRECTIONS-OPERATING	09.255
1875	CORRECTIONS-OPERATING	09.260
1876	CORRECTIONS-OPERATING	09.265
1877	CORRECTIONS-OPERATING	09.265
1878	CORRECTIONS-OPERATING	09.270
1879	CORRECTIONS-OPERATING	09.270
1880	CORRECTIONS-OPERATING	09.270
1881	CORRECTIONS-OPERATING	09.270
1882	CORRECTIONS-OPERATING	09.275
1883	CORRECTIONS-OPERATING	09.280
1884	MENTAL HEALTH-OPERATING	10.005
1885	MENTAL HEALTH-OPERATING	10.005
1886	MENTAL HEALTH-OPERATING	10.005
1887	MENTAL HEALTH-OPERATING	10.005
1888	MENTAL HEALTH-OPERATING	10.006
1889	MENTAL HEALTH-OPERATING	10.006
1890	MENTAL HEALTH-OPERATING	10.006
1891	MENTAL HEALTH-OPERATING	10.010
1892	MENTAL HEALTH-OPERATING	10.015
1893	MENTAL HEALTH-OPERATING	10.020
1894	MENTAL HEALTH-OPERATING	10.020
1895	MENTAL HEALTH-OPERATING	10.020
1896	MENTAL HEALTH-OPERATING	10.020
1897	MENTAL HEALTH-OPERATING	10.020
1898	MENTAL HEALTH-OPERATING	10.020
1899	MENTAL HEALTH-OPERATING	10.020
1900	MENTAL HEALTH-OPERATING	10.020
1901	MENTAL HEALTH-OPERATING	10.025
1902	MENTAL HEALTH-OPERATING	10.025
1903	MENTAL HEALTH-OPERATING	10.025
1904	MENTAL HEALTH-OPERATING	10.025
1905	MENTAL HEALTH-OPERATING	10.025
1906	MENTAL HEALTH-OPERATING	10.025
1907	MENTAL HEALTH-OPERATING	10.030
1908	MENTAL HEALTH-OPERATING	10.030
1909	MENTAL HEALTH-OPERATING	10.030
1910	MENTAL HEALTH-OPERATING	10.030
1911	MENTAL HEALTH-OPERATING	10.030
1912	MENTAL HEALTH-OPERATING	10.030
1913	MENTAL HEALTH-OPERATING	10.030
1914	MENTAL HEALTH-OPERATING	10.030

Exhibit A

#	Agnecy	Budget Appropriation Line
1915	MENTAL HEALTH-OPERATING	10.030
1916	MENTAL HEALTH-OPERATING	10.030
1917	MENTAL HEALTH-OPERATING	10.030
1918	MENTAL HEALTH-OPERATING	10.035
1919	MENTAL HEALTH-OPERATING	10.040
1920	MENTAL HEALTH-OPERATING	10.040
1921	MENTAL HEALTH-OPERATING	10.040
1922	MENTAL HEALTH-OPERATING	10.045
1923	MENTAL HEALTH-OPERATING	10.045
1924	MENTAL HEALTH-OPERATING	10.050
1925	MENTAL HEALTH-OPERATING	10.050
1926	MENTAL HEALTH-OPERATING	10.050
1927	MENTAL HEALTH-OPERATING	10.055
1928	MENTAL HEALTH-OPERATING	10.055
1929	MENTAL HEALTH-OPERATING	10.065
1930	MENTAL HEALTH-OPERATING	10.070
1931	MENTAL HEALTH-OPERATING	10.075
1932	MENTAL HEALTH-OPERATING	10.100
1933	MENTAL HEALTH-OPERATING	10.100
1934	MENTAL HEALTH-OPERATING	10.100
1935	MENTAL HEALTH-OPERATING	10.100
1936	MENTAL HEALTH-OPERATING	10.100
1937	MENTAL HEALTH-OPERATING	10.105
1938	MENTAL HEALTH-OPERATING	10.105
1939	MENTAL HEALTH-OPERATING	10.105
1940	MENTAL HEALTH-OPERATING	10.105
1941	MENTAL HEALTH-OPERATING	10.105
1942	MENTAL HEALTH-OPERATING	10.105
1943	MENTAL HEALTH-OPERATING	10.105
1944	MENTAL HEALTH-OPERATING	10.105
1945	MENTAL HEALTH-OPERATING	10.105
1946	MENTAL HEALTH-OPERATING	10.105
1947	MENTAL HEALTH-OPERATING	10.105
1948	MENTAL HEALTH-OPERATING	10.105
1949	MENTAL HEALTH-OPERATING	10.110
1950	MENTAL HEALTH-OPERATING	10.110
1951	MENTAL HEALTH-OPERATING	10.110
1952	MENTAL HEALTH-OPERATING	10.110
1953	MENTAL HEALTH-OPERATING	10.110
1954	MENTAL HEALTH-OPERATING	10.110
1955	MENTAL HEALTH-OPERATING	10.110
1956	MENTAL HEALTH-OPERATING	10.110
1957	MENTAL HEALTH-OPERATING	10.110
1958	MENTAL HEALTH-OPERATING	10.110
1959	MENTAL HEALTH-OPERATING	10.110
1960	MENTAL HEALTH-OPERATING	10.110
1961	MENTAL HEALTH-OPERATING	10.110
1962	MENTAL HEALTH-OPERATING	10.110
1963	MENTAL HEALTH-OPERATING	10.110
1964	MENTAL HEALTH-OPERATING	10.115
1965	MENTAL HEALTH-OPERATING	10.120
1966	MENTAL HEALTH-OPERATING	10.120
1967	MENTAL HEALTH-OPERATING	10.120
1968	MENTAL HEALTH-OPERATING	10.120
1969	MENTAL HEALTH-OPERATING	10.120
1970	MENTAL HEALTH-OPERATING	10.200
1971	MENTAL HEALTH-OPERATING	10.200
1972	MENTAL HEALTH-OPERATING	10.200

Exhibit A

#	Agnecy	Budget Appropriation Line
1973	MENTAL HEALTH-OPERATING	10.200
1974	MENTAL HEALTH-OPERATING	10.200
1975	MENTAL HEALTH-OPERATING	10.200
1976	MENTAL HEALTH-OPERATING	10.200
1977	MENTAL HEALTH-OPERATING	10.205
1978	MENTAL HEALTH-OPERATING	10.205
1979	MENTAL HEALTH-OPERATING	10.205
1980	MENTAL HEALTH-OPERATING	10.205
1981	MENTAL HEALTH-OPERATING	10.205
1982	MENTAL HEALTH-OPERATING	10.205
1983	MENTAL HEALTH-OPERATING	10.205
1984	MENTAL HEALTH-OPERATING	10.210
1985	MENTAL HEALTH-OPERATING	10.210
1986	MENTAL HEALTH-OPERATING	10.210
1987	MENTAL HEALTH-OPERATING	10.210
1988	MENTAL HEALTH-OPERATING	10.210
1989	MENTAL HEALTH-OPERATING	10.210
1990	MENTAL HEALTH-OPERATING	10.210
1991	MENTAL HEALTH-OPERATING	10.210
1992	MENTAL HEALTH-OPERATING	10.210
1993	MENTAL HEALTH-OPERATING	10.210
1994	MENTAL HEALTH-OPERATING	10.210
1995	MENTAL HEALTH-OPERATING	10.210
1996	MENTAL HEALTH-OPERATING	10.210
1997	MENTAL HEALTH-OPERATING	10.210
1998	MENTAL HEALTH-OPERATING	10.210
1999	MENTAL HEALTH-OPERATING	10.210
2000	MENTAL HEALTH-OPERATING	10.215
2001	MENTAL HEALTH-OPERATING	10.220
2002	MENTAL HEALTH-OPERATING	10.220
2003	MENTAL HEALTH-OPERATING	10.220
2004	MENTAL HEALTH-OPERATING	10.220
2005	MENTAL HEALTH-OPERATING	10.225
2006	MENTAL HEALTH-OPERATING	10.225
2007	MENTAL HEALTH-OPERATING	10.225
2008	MENTAL HEALTH-OPERATING	10.225
2009	MENTAL HEALTH-OPERATING	10.225
2010	MENTAL HEALTH-OPERATING	10.225
2011	MENTAL HEALTH-OPERATING	10.225
2012	MENTAL HEALTH-OPERATING	10.225
2013	MENTAL HEALTH-OPERATING	10.230
2014	MENTAL HEALTH-OPERATING	10.235
2015	MENTAL HEALTH-OPERATING	10.235
2016	MENTAL HEALTH-OPERATING	10.300
2017	MENTAL HEALTH-OPERATING	10.300
2018	MENTAL HEALTH-OPERATING	10.300
2019	MENTAL HEALTH-OPERATING	10.300
2020	MENTAL HEALTH-OPERATING	10.300
2021	MENTAL HEALTH-OPERATING	10.300
2022	MENTAL HEALTH-OPERATING	10.300
2023	MENTAL HEALTH-OPERATING	10.300
2024	MENTAL HEALTH-OPERATING	10.300
2025	MENTAL HEALTH-OPERATING	10.305
2026	MENTAL HEALTH-OPERATING	10.305
2027	MENTAL HEALTH-OPERATING	10.305
2028	MENTAL HEALTH-OPERATING	10.305
2029	MENTAL HEALTH-OPERATING	10.305
2030	MENTAL HEALTH-OPERATING	10.305

Exhibit A

#	Agnecy	Budget Appropriation Line
2031	MENTAL HEALTH-OPERATING	10.310
2032	MENTAL HEALTH-OPERATING	10.310
2033	MENTAL HEALTH-OPERATING	10.310
2034	MENTAL HEALTH-OPERATING	10.310
2035	MENTAL HEALTH-OPERATING	10.310
2036	MENTAL HEALTH-OPERATING	10.310
2037	MENTAL HEALTH-OPERATING	10.315
2038	MENTAL HEALTH-OPERATING	10.320
2039	MENTAL HEALTH-OPERATING	10.320
2040	MENTAL HEALTH-OPERATING	10.320
2041	MENTAL HEALTH-OPERATING	10.320
2042	MENTAL HEALTH-OPERATING	10.320
2043	MENTAL HEALTH-OPERATING	10.325
2044	MENTAL HEALTH-OPERATING	10.325
2045	MENTAL HEALTH-OPERATING	10.325
2046	MENTAL HEALTH-OPERATING	10.325
2047	MENTAL HEALTH-OPERATING	10.325
2048	MENTAL HEALTH-OPERATING	10.325
2049	MENTAL HEALTH-OPERATING	10.325
2050	MENTAL HEALTH-OPERATING	10.325
2051	MENTAL HEALTH-OPERATING	10.325
2052	MENTAL HEALTH-OPERATING	10.330
2053	MENTAL HEALTH-OPERATING	10.330
2054	MENTAL HEALTH-OPERATING	10.330
2055	MENTAL HEALTH-OPERATING	10.330
2056	MENTAL HEALTH-OPERATING	10.330
2057	MENTAL HEALTH-OPERATING	10.330
2058	MENTAL HEALTH-OPERATING	10.335
2059	MENTAL HEALTH-OPERATING	10.335
2060	MENTAL HEALTH-OPERATING	10.335
2061	MENTAL HEALTH-OPERATING	10.335
2062	MENTAL HEALTH-OPERATING	10.335
2063	MENTAL HEALTH-OPERATING	10.335
2064	MENTAL HEALTH-OPERATING	10.335
2065	MENTAL HEALTH-OPERATING	10.400
2066	MENTAL HEALTH-OPERATING	10.400
2067	MENTAL HEALTH-OPERATING	10.400
2068	MENTAL HEALTH-OPERATING	10.400
2069	MENTAL HEALTH-OPERATING	10.405
2070	MENTAL HEALTH-OPERATING	10.410
2071	MENTAL HEALTH-OPERATING	10.410
2072	MENTAL HEALTH-OPERATING	10.410
2073	MENTAL HEALTH-OPERATING	10.410
2074	MENTAL HEALTH-OPERATING	10.410
2075	MENTAL HEALTH-OPERATING	10.410
2076	MENTAL HEALTH-OPERATING	10.410
2077	MENTAL HEALTH-OPERATING	10.410
2078	MENTAL HEALTH-OPERATING	10.410
2079	MENTAL HEALTH-OPERATING	10.410
2080	MENTAL HEALTH-OPERATING	10.410
2081	MENTAL HEALTH-OPERATING	10.410
2082	MENTAL HEALTH-OPERATING	10.410
2083	MENTAL HEALTH-OPERATING	10.410
2084	MENTAL HEALTH-OPERATING	10.410
2085	MENTAL HEALTH-OPERATING	10.415
2086	MENTAL HEALTH-OPERATING	10.415
2087	MENTAL HEALTH-OPERATING	10.420
2088	MENTAL HEALTH-OPERATING	10.420

Exhibit A

#	Agnecy	Budget Appropriation Line
2089	MENTAL HEALTH-OPERATING	10.425
2090	MENTAL HEALTH-OPERATING	10.425
2091	MENTAL HEALTH-OPERATING	10.500
2092	MENTAL HEALTH-OPERATING	10.500
2093	MENTAL HEALTH-OPERATING	10.500
2094	MENTAL HEALTH-OPERATING	10.500
2095	MENTAL HEALTH-OPERATING	10.505
2096	MENTAL HEALTH-OPERATING	10.505
2097	MENTAL HEALTH-OPERATING	10.505
2098	MENTAL HEALTH-OPERATING	10.505
2099	MENTAL HEALTH-OPERATING	10.510
2100	MENTAL HEALTH-OPERATING	10.510
2101	MENTAL HEALTH-OPERATING	10.510
2102	MENTAL HEALTH-OPERATING	10.510
2103	MENTAL HEALTH-OPERATING	10.515
2104	MENTAL HEALTH-OPERATING	10.515
2105	MENTAL HEALTH-OPERATING	10.515
2106	MENTAL HEALTH-OPERATING	10.515
2107	MENTAL HEALTH-OPERATING	10.520
2108	MENTAL HEALTH-OPERATING	10.520
2109	MENTAL HEALTH-OPERATING	10.520
2110	MENTAL HEALTH-OPERATING	10.520
2111	MENTAL HEALTH-OPERATING	10.525
2112	MENTAL HEALTH-OPERATING	10.525
2113	MENTAL HEALTH-OPERATING	10.525
2114	MENTAL HEALTH-OPERATING	10.525
2115	MENTAL HEALTH-OPERATING	10.525
2116	MENTAL HEALTH-OPERATING	10.525
2117	MENTAL HEALTH-OPERATING	10.530
2118	MENTAL HEALTH-OPERATING	10.530
2119	MENTAL HEALTH-OPERATING	10.530
2120	MENTAL HEALTH-OPERATING	10.530
2121	MENTAL HEALTH-OPERATING	10.530
2122	MENTAL HEALTH-OPERATING	10.530
2123	MENTAL HEALTH-OPERATING	10.535
2124	MENTAL HEALTH-OPERATING	10.535
2125	MENTAL HEALTH-OPERATING	10.535
2126	MENTAL HEALTH-OPERATING	10.535
2127	MENTAL HEALTH-OPERATING	10.535
2128	MENTAL HEALTH-OPERATING	10.540
2129	MENTAL HEALTH-OPERATING	10.540
2130	MENTAL HEALTH-OPERATING	10.540
2131	MENTAL HEALTH-OPERATING	10.540
2132	MENTAL HEALTH-OPERATING	10.540
2133	MENTAL HEALTH-OPERATING	10.540
2134	MENTAL HEALTH-OPERATING	10.545
2135	MENTAL HEALTH-OPERATING	10.545
2136	MENTAL HEALTH-OPERATING	10.545
2137	MENTAL HEALTH-OPERATING	10.545
2138	MENTAL HEALTH-OPERATING	10.550
2139	MENTAL HEALTH-OPERATING	10.550
2140	MENTAL HEALTH-OPERATING	10.550
2141	MENTAL HEALTH-OPERATING	10.550
2142	MENTAL HEALTH-OPERATING	10.550
2143	MENTAL HEALTH-OPERATING	10.550
2144	MENTAL HEALTH-OPERATING	10.555
2145	MENTAL HEALTH-OPERATING	10.575
2146	HEALTH & SENIOR SERVICES-OPER	10.600

Exhibit A

#	Agnecy	Budget Appropriation Line
2147	HEALTH & SENIOR SERVICES-OPER	10.600
2148	HEALTH & SENIOR SERVICES-OPER	10.600
2149	HEALTH & SENIOR SERVICES-OPER	10.600
2150	HEALTH & SENIOR SERVICES-OPER	10.605
2151	HEALTH & SENIOR SERVICES-OPER	10.605
2152	HEALTH & SENIOR SERVICES-OPER	10.605
2153	HEALTH & SENIOR SERVICES-OPER	10.605
2154	HEALTH & SENIOR SERVICES-OPER	10.605
2155	HEALTH & SENIOR SERVICES-OPER	10.605
2156	HEALTH & SENIOR SERVICES-OPER	10.605
2157	HEALTH & SENIOR SERVICES-OPER	10.605
2158	HEALTH & SENIOR SERVICES-OPER	10.605
2159	HEALTH & SENIOR SERVICES-OPER	10.605
2160	HEALTH & SENIOR SERVICES-OPER	10.605
2161	HEALTH & SENIOR SERVICES-OPER	10.605
2162	HEALTH & SENIOR SERVICES-OPER	10.605
2163	HEALTH & SENIOR SERVICES-OPER	10.605
2164	HEALTH & SENIOR SERVICES-OPER	10.605
2165	HEALTH & SENIOR SERVICES-OPER	10.605
2166	HEALTH & SENIOR SERVICES-OPER	10.605
2167	HEALTH & SENIOR SERVICES-OPER	10.606
2168	HEALTH & SENIOR SERVICES-OPER	10.606
2169	HEALTH & SENIOR SERVICES-OPER	10.606
2170	HEALTH & SENIOR SERVICES-OPER	10.610
2171	HEALTH & SENIOR SERVICES-OPER	10.615
2172	HEALTH & SENIOR SERVICES-OPER	10.620
2173	HEALTH & SENIOR SERVICES-OPER	10.620
2174	HEALTH & SENIOR SERVICES-OPER	10.620
2175	HEALTH & SENIOR SERVICES-OPER	10.620
2176	HEALTH & SENIOR SERVICES-OPER	10.620
2177	HEALTH & SENIOR SERVICES-OPER	10.620
2178	HEALTH & SENIOR SERVICES-OPER	10.620
2179	HEALTH & SENIOR SERVICES-OPER	10.620
2180	HEALTH & SENIOR SERVICES-OPER	10.620
2181	HEALTH & SENIOR SERVICES-OPER	10.620
2182	HEALTH & SENIOR SERVICES-OPER	10.620
2183	HEALTH & SENIOR SERVICES-OPER	10.620
2184	HEALTH & SENIOR SERVICES-OPER	10.620
2185	HEALTH & SENIOR SERVICES-OPER	10.620
2186	HEALTH & SENIOR SERVICES-OPER	10.625
2187	HEALTH & SENIOR SERVICES-OPER	10.625
2188	HEALTH & SENIOR SERVICES-OPER	10.625
2189	HEALTH & SENIOR SERVICES-OPER	10.625
2190	HEALTH & SENIOR SERVICES-OPER	10.700
2191	HEALTH & SENIOR SERVICES-OPER	10.700
2192	HEALTH & SENIOR SERVICES-OPER	10.700
2193	HEALTH & SENIOR SERVICES-OPER	10.700
2194	HEALTH & SENIOR SERVICES-OPER	10.700
2195	HEALTH & SENIOR SERVICES-OPER	10.700
2196	HEALTH & SENIOR SERVICES-OPER	10.700
2197	HEALTH & SENIOR SERVICES-OPER	10.700
2198	HEALTH & SENIOR SERVICES-OPER	10.700
2199	HEALTH & SENIOR SERVICES-OPER	10.700
2200	HEALTH & SENIOR SERVICES-OPER	10.700
2201	HEALTH & SENIOR SERVICES-OPER	10.700
2202	HEALTH & SENIOR SERVICES-OPER	10.700
2203	HEALTH & SENIOR SERVICES-OPER	10.700
2204	HEALTH & SENIOR SERVICES-OPER	10.700

Exhibit A

#	Agnecy	Budget Appropriation Line
2205	HEALTH & SENIOR SERVICES-OPER	10.700
2206	HEALTH & SENIOR SERVICES-OPER	10.700
2207	HEALTH & SENIOR SERVICES-OPER	10.700
2208	HEALTH & SENIOR SERVICES-OPER	10.700
2209	HEALTH & SENIOR SERVICES-OPER	10.700
2210	HEALTH & SENIOR SERVICES-OPER	10.700
2211	HEALTH & SENIOR SERVICES-OPER	10.700
2212	HEALTH & SENIOR SERVICES-OPER	10.700
2213	HEALTH & SENIOR SERVICES-OPER	10.700
2214	HEALTH & SENIOR SERVICES-OPER	10.700
2215	HEALTH & SENIOR SERVICES-OPER	10.700
2216	HEALTH & SENIOR SERVICES-OPER	10.700
2217	HEALTH & SENIOR SERVICES-OPER	10.700
2218	HEALTH & SENIOR SERVICES-OPER	10.705
2219	HEALTH & SENIOR SERVICES-OPER	10.705
2220	HEALTH & SENIOR SERVICES-OPER	10.710
2221	HEALTH & SENIOR SERVICES-OPER	10.710
2222	HEALTH & SENIOR SERVICES-OPER	10.710
2223	HEALTH & SENIOR SERVICES-OPER	10.710
2224	HEALTH & SENIOR SERVICES-OPER	10.710
2225	HEALTH & SENIOR SERVICES-OPER	10.710
2226	HEALTH & SENIOR SERVICES-OPER	10.710
2227	HEALTH & SENIOR SERVICES-OPER	10.710
2228	HEALTH & SENIOR SERVICES-OPER	10.710
2229	HEALTH & SENIOR SERVICES-OPER	10.710
2230	HEALTH & SENIOR SERVICES-OPER	10.710
2231	HEALTH & SENIOR SERVICES-OPER	10.710
2232	HEALTH & SENIOR SERVICES-OPER	10.710
2233	HEALTH & SENIOR SERVICES-OPER	10.710
2234	HEALTH & SENIOR SERVICES-OPER	10.710
2235	HEALTH & SENIOR SERVICES-OPER	10.710
2236	HEALTH & SENIOR SERVICES-OPER	10.710
2237	HEALTH & SENIOR SERVICES-OPER	10.710
2238	HEALTH & SENIOR SERVICES-OPER	10.710
2239	HEALTH & SENIOR SERVICES-OPER	10.710
2240	HEALTH & SENIOR SERVICES-OPER	10.710
2241	HEALTH & SENIOR SERVICES-OPER	10.710
2242	HEALTH & SENIOR SERVICES-OPER	10.710
2243	HEALTH & SENIOR SERVICES-OPER	10.715
2244	HEALTH & SENIOR SERVICES-OPER	10.715
2245	HEALTH & SENIOR SERVICES-OPER	10.715
2246	HEALTH & SENIOR SERVICES-OPER	10.715
2247	HEALTH & SENIOR SERVICES-OPER	10.715
2248	HEALTH & SENIOR SERVICES-OPER	10.715
2249	HEALTH & SENIOR SERVICES-OPER	10.720
2250	HEALTH & SENIOR SERVICES-OPER	10.720
2251	HEALTH & SENIOR SERVICES-OPER	10.730
2252	HEALTH & SENIOR SERVICES-OPER	10.735
2253	HEALTH & SENIOR SERVICES-OPER	10.735
2254	HEALTH & SENIOR SERVICES-OPER	10.735
2255	HEALTH & SENIOR SERVICES-OPER	10.740
2256	HEALTH & SENIOR SERVICES-OPER	10.740
2257	HEALTH & SENIOR SERVICES-OPER	10.740
2258	HEALTH & SENIOR SERVICES-OPER	10.740
2259	HEALTH & SENIOR SERVICES-OPER	10.740
2260	HEALTH & SENIOR SERVICES-OPER	10.740
2261	HEALTH & SENIOR SERVICES-OPER	10.740
2262	HEALTH & SENIOR SERVICES-OPER	10.740

Exhibit A

#	Agnecy	Budget Appropriation Line
2263	HEALTH & SENIOR SERVICES-OPER	10.740
2264	HEALTH & SENIOR SERVICES-OPER	10.740
2265	HEALTH & SENIOR SERVICES-OPER	10.740
2266	HEALTH & SENIOR SERVICES-OPER	10.740
2267	HEALTH & SENIOR SERVICES-OPER	10.745
2268	HEALTH & SENIOR SERVICES-OPER	10.745
2269	HEALTH & SENIOR SERVICES-OPER	10.745
2270	HEALTH & SENIOR SERVICES-OPER	10.745
2271	HEALTH & SENIOR SERVICES-OPER	10.745
2272	HEALTH & SENIOR SERVICES-OPER	10.750
2273	HEALTH & SENIOR SERVICES-OPER	10.750
2274	HEALTH & SENIOR SERVICES-OPER	10.750
2275	HEALTH & SENIOR SERVICES-OPER	10.755
2276	HEALTH & SENIOR SERVICES-OPER	10.755
2277	HEALTH & SENIOR SERVICES-OPER	10.755
2278	HEALTH & SENIOR SERVICES-OPER	10.760
2279	HEALTH & SENIOR SERVICES-OPER	10.760
2280	HEALTH & SENIOR SERVICES-OPER	10.760
2281	HEALTH & SENIOR SERVICES-OPER	10.760
2282	HEALTH & SENIOR SERVICES-OPER	10.760
2283	HEALTH & SENIOR SERVICES-OPER	10.760
2284	HEALTH & SENIOR SERVICES-OPER	10.760
2285	HEALTH & SENIOR SERVICES-OPER	10.760
2286	HEALTH & SENIOR SERVICES-OPER	10.760
2287	HEALTH & SENIOR SERVICES-OPER	10.760
2288	HEALTH & SENIOR SERVICES-OPER	10.760
2289	HEALTH & SENIOR SERVICES-OPER	10.800
2290	HEALTH & SENIOR SERVICES-OPER	10.800
2291	HEALTH & SENIOR SERVICES-OPER	10.800
2292	HEALTH & SENIOR SERVICES-OPER	10.800
2293	HEALTH & SENIOR SERVICES-OPER	10.800
2294	HEALTH & SENIOR SERVICES-OPER	10.800
2295	HEALTH & SENIOR SERVICES-OPER	10.800
2296	HEALTH & SENIOR SERVICES-OPER	10.800
2297	HEALTH & SENIOR SERVICES-OPER	10.800
2298	HEALTH & SENIOR SERVICES-OPER	10.800
2299	HEALTH & SENIOR SERVICES-OPER	10.800
2300	HEALTH & SENIOR SERVICES-OPER	10.800
2301	HEALTH & SENIOR SERVICES-OPER	10.805
2302	HEALTH & SENIOR SERVICES-OPER	10.805
2303	HEALTH & SENIOR SERVICES-OPER	10.805
2304	HEALTH & SENIOR SERVICES-OPER	10.810
2305	HEALTH & SENIOR SERVICES-OPER	10.810
2306	HEALTH & SENIOR SERVICES-OPER	10.815
2307	HEALTH & SENIOR SERVICES-OPER	10.815
2308	HEALTH & SENIOR SERVICES-OPER	10.820
2309	HEALTH & SENIOR SERVICES-OPER	10.820
2310	HEALTH & SENIOR SERVICES-OPER	10.820
2311	HEALTH & SENIOR SERVICES-OPER	10.820
2312	HEALTH & SENIOR SERVICES-OPER	10.820
2313	HEALTH & SENIOR SERVICES-OPER	10.820
2314	HEALTH & SENIOR SERVICES-OPER	10.825
2315	HEALTH & SENIOR SERVICES-OPER	10.825
2316	HEALTH & SENIOR SERVICES-OPER	10.830
2317	HEALTH & SENIOR SERVICES-OPER	10.835
2318	HEALTH & SENIOR SERVICES-OPER	10.900
2319	HEALTH & SENIOR SERVICES-OPER	10.900
2320	HEALTH & SENIOR SERVICES-OPER	10.900

Exhibit A

#	Agnecy	Budget Appropriation Line
2321	HEALTH & SENIOR SERVICES-OPER	10.900
2322	HEALTH & SENIOR SERVICES-OPER	10.900
2323	HEALTH & SENIOR SERVICES-OPER	10.900
2324	HEALTH & SENIOR SERVICES-OPER	10.900
2325	HEALTH & SENIOR SERVICES-OPER	10.900
2326	HEALTH & SENIOR SERVICES-OPER	10.900
2327	HEALTH & SENIOR SERVICES-OPER	10.900
2328	HEALTH & SENIOR SERVICES-OPER	10.900
2329	HEALTH & SENIOR SERVICES-OPER	10.900
2330	HEALTH & SENIOR SERVICES-OPER	10.900
2331	HEALTH & SENIOR SERVICES-OPER	10.900
2332	HEALTH & SENIOR SERVICES-OPER	10.900
2333	HEALTH & SENIOR SERVICES-OPER	10.900
2334	HEALTH & SENIOR SERVICES-OPER	10.900
2335	HEALTH & SENIOR SERVICES-OPER	10.900
2336	HEALTH & SENIOR SERVICES-OPER	10.900
2337	HEALTH & SENIOR SERVICES-OPER	10.900
2338	HEALTH & SENIOR SERVICES-OPER	10.900
2339	HEALTH & SENIOR SERVICES-OPER	10.900
2340	HEALTH & SENIOR SERVICES-OPER	10.900
2341	HEALTH & SENIOR SERVICES-OPER	10.900
2342	HEALTH & SENIOR SERVICES-OPER	10.900
2343	HEALTH & SENIOR SERVICES-OPER	10.900
2344	HEALTH & SENIOR SERVICES-OPER	10.905
2345	HEALTH & SENIOR SERVICES-OPER	10.955
2346	SOCIAL SERVICES-OPERATING	11.005
2347	SOCIAL SERVICES-OPERATING	11.005
2348	SOCIAL SERVICES-OPERATING	11.005
2349	SOCIAL SERVICES-OPERATING	11.005
2350	SOCIAL SERVICES-OPERATING	11.005
2351	SOCIAL SERVICES-OPERATING	11.006
2352	SOCIAL SERVICES-OPERATING	11.006
2353	SOCIAL SERVICES-OPERATING	11.006
2354	SOCIAL SERVICES-OPERATING	11.010
2355	SOCIAL SERVICES-OPERATING	11.010
2356	SOCIAL SERVICES-OPERATING	11.015
2357	SOCIAL SERVICES-OPERATING	11.015
2358	SOCIAL SERVICES-OPERATING	11.015
2359	SOCIAL SERVICES-OPERATING	11.015
2360	SOCIAL SERVICES-OPERATING	11.020
2361	SOCIAL SERVICES-OPERATING	11.020
2362	SOCIAL SERVICES-OPERATING	11.020
2363	SOCIAL SERVICES-OPERATING	11.020
2364	SOCIAL SERVICES-OPERATING	11.020
2365	SOCIAL SERVICES-OPERATING	11.020
2366	SOCIAL SERVICES-OPERATING	11.020
2367	SOCIAL SERVICES-OPERATING	11.025
2368	SOCIAL SERVICES-OPERATING	11.025
2369	SOCIAL SERVICES-OPERATING	11.030
2370	SOCIAL SERVICES-OPERATING	11.035
2371	SOCIAL SERVICES-OPERATING	11.035
2372	SOCIAL SERVICES-OPERATING	11.035
2373	SOCIAL SERVICES-OPERATING	11.035
2374	SOCIAL SERVICES-OPERATING	11.035
2375	SOCIAL SERVICES-OPERATING	11.035
2376	SOCIAL SERVICES-OPERATING	11.035
2377	SOCIAL SERVICES-OPERATING	11.035
2378	SOCIAL SERVICES-OPERATING	11.040

Exhibit A

#	Agnecy	Budget Appropriation Line
2379	SOCIAL SERVICES-OPERATING	11.045
2380	SOCIAL SERVICES-OPERATING	11.045
2381	SOCIAL SERVICES-OPERATING	11.045
2382	SOCIAL SERVICES-OPERATING	11.045
2383	SOCIAL SERVICES-OPERATING	11.045
2384	SOCIAL SERVICES-OPERATING	11.045
2385	SOCIAL SERVICES-OPERATING	11.045
2386	SOCIAL SERVICES-OPERATING	11.050
2387	SOCIAL SERVICES-OPERATING	11.055
2388	SOCIAL SERVICES-OPERATING	11.055
2389	SOCIAL SERVICES-OPERATING	11.055
2390	SOCIAL SERVICES-OPERATING	11.055
2391	SOCIAL SERVICES-OPERATING	11.055
2392	SOCIAL SERVICES-OPERATING	11.055
2393	SOCIAL SERVICES-OPERATING	11.055
2394	SOCIAL SERVICES-OPERATING	11.100
2395	SOCIAL SERVICES-OPERATING	11.100
2396	SOCIAL SERVICES-OPERATING	11.100
2397	SOCIAL SERVICES-OPERATING	11.100
2398	SOCIAL SERVICES-OPERATING	11.100
2399	SOCIAL SERVICES-OPERATING	11.100
2400	SOCIAL SERVICES-OPERATING	11.100
2401	SOCIAL SERVICES-OPERATING	11.105
2402	SOCIAL SERVICES-OPERATING	11.105
2403	SOCIAL SERVICES-OPERATING	11.105
2404	SOCIAL SERVICES-OPERATING	11.105
2405	SOCIAL SERVICES-OPERATING	11.105
2406	SOCIAL SERVICES-OPERATING	11.105
2407	SOCIAL SERVICES-OPERATING	11.105
2408	SOCIAL SERVICES-OPERATING	11.105
2409	SOCIAL SERVICES-OPERATING	11.110
2410	SOCIAL SERVICES-OPERATING	11.110
2411	SOCIAL SERVICES-OPERATING	11.115
2412	SOCIAL SERVICES-OPERATING	11.115
2413	SOCIAL SERVICES-OPERATING	11.120
2414	SOCIAL SERVICES-OPERATING	11.125
2415	SOCIAL SERVICES-OPERATING	11.125
2416	SOCIAL SERVICES-OPERATING	11.125
2417	SOCIAL SERVICES-OPERATING	11.130
2418	SOCIAL SERVICES-OPERATING	11.130
2419	SOCIAL SERVICES-OPERATING	11.130
2420	SOCIAL SERVICES-OPERATING	11.135
2421	SOCIAL SERVICES-OPERATING	11.135
2422	SOCIAL SERVICES-OPERATING	11.135
2423	SOCIAL SERVICES-OPERATING	11.135
2424	SOCIAL SERVICES-OPERATING	11.135
2425	SOCIAL SERVICES-OPERATING	11.135
2426	SOCIAL SERVICES-OPERATING	11.135
2427	SOCIAL SERVICES-OPERATING	11.140
2428	SOCIAL SERVICES-OPERATING	11.140
2429	SOCIAL SERVICES-OPERATING	11.140
2430	SOCIAL SERVICES-OPERATING	11.145
2431	SOCIAL SERVICES-OPERATING	11.150
2432	SOCIAL SERVICES-OPERATING	11.150
2433	SOCIAL SERVICES-OPERATING	11.150
2434	SOCIAL SERVICES-OPERATING	11.150
2435	SOCIAL SERVICES-OPERATING	11.150
2436	SOCIAL SERVICES-OPERATING	11.150

Exhibit A

#	Agnecy	Budget Appropriation Line
2437	SOCIAL SERVICES-OPERATING	11.150
2438	SOCIAL SERVICES-OPERATING	11.150
2439	SOCIAL SERVICES-OPERATING	11.150
2440	SOCIAL SERVICES-OPERATING	11.150
2441	SOCIAL SERVICES-OPERATING	11.150
2442	SOCIAL SERVICES-OPERATING	11.150
2443	SOCIAL SERVICES-OPERATING	11.150
2444	SOCIAL SERVICES-OPERATING	11.150
2445	SOCIAL SERVICES-OPERATING	11.150
2446	SOCIAL SERVICES-OPERATING	11.150
2447	SOCIAL SERVICES-OPERATING	11.150
2448	SOCIAL SERVICES-OPERATING	11.150
2449	SOCIAL SERVICES-OPERATING	11.155
2450	SOCIAL SERVICES-OPERATING	11.155
2451	SOCIAL SERVICES-OPERATING	11.155
2452	SOCIAL SERVICES-OPERATING	11.155
2453	SOCIAL SERVICES-OPERATING	11.155
2454	SOCIAL SERVICES-OPERATING	11.165
2455	SOCIAL SERVICES-OPERATING	11.170
2456	SOCIAL SERVICES-OPERATING	11.170
2457	SOCIAL SERVICES-OPERATING	11.170
2458	SOCIAL SERVICES-OPERATING	11.170
2459	SOCIAL SERVICES-OPERATING	11.175
2460	SOCIAL SERVICES-OPERATING	11.180
2461	SOCIAL SERVICES-OPERATING	11.185
2462	SOCIAL SERVICES-OPERATING	11.190
2463	SOCIAL SERVICES-OPERATING	11.195
2464	SOCIAL SERVICES-OPERATING	11.195
2465	SOCIAL SERVICES-OPERATING	11.195
2466	SOCIAL SERVICES-OPERATING	11.195
2467	SOCIAL SERVICES-OPERATING	11.200
2468	SOCIAL SERVICES-OPERATING	11.200
2469	SOCIAL SERVICES-OPERATING	11.200
2470	SOCIAL SERVICES-OPERATING	11.200
2471	SOCIAL SERVICES-OPERATING	11.200
2472	SOCIAL SERVICES-OPERATING	11.200
2473	SOCIAL SERVICES-OPERATING	11.205
2474	SOCIAL SERVICES-OPERATING	11.205
2475	SOCIAL SERVICES-OPERATING	11.205
2476	SOCIAL SERVICES-OPERATING	11.210
2477	SOCIAL SERVICES-OPERATING	11.210
2478	SOCIAL SERVICES-OPERATING	11.210
2479	SOCIAL SERVICES-OPERATING	11.210
2480	SOCIAL SERVICES-OPERATING	11.215
2481	SOCIAL SERVICES-OPERATING	11.215
2482	SOCIAL SERVICES-OPERATING	11.215
2483	SOCIAL SERVICES-OPERATING	11.215
2484	SOCIAL SERVICES-OPERATING	11.220
2485	SOCIAL SERVICES-OPERATING	11.225
2486	SOCIAL SERVICES-OPERATING	11.225
2487	SOCIAL SERVICES-OPERATING	11.225
2488	SOCIAL SERVICES-OPERATING	11.225
2489	SOCIAL SERVICES-OPERATING	11.225
2490	SOCIAL SERVICES-OPERATING	11.225
2491	SOCIAL SERVICES-OPERATING	11.230
2492	SOCIAL SERVICES-OPERATING	11.230
2493	SOCIAL SERVICES-OPERATING	11.230
2494	SOCIAL SERVICES-OPERATING	11.235

Exhibit A

#	Agnecy	Budget Appropriation Line
2495	SOCIAL SERVICES-OPERATING	11.235
2496	SOCIAL SERVICES-OPERATING	11.240
2497	SOCIAL SERVICES-OPERATING	11.240
2498	SOCIAL SERVICES-OPERATING	11.300
2499	SOCIAL SERVICES-OPERATING	11.300
2500	SOCIAL SERVICES-OPERATING	11.300
2501	SOCIAL SERVICES-OPERATING	11.300
2502	SOCIAL SERVICES-OPERATING	11.300
2503	SOCIAL SERVICES-OPERATING	11.305
2504	SOCIAL SERVICES-OPERATING	11.305
2505	SOCIAL SERVICES-OPERATING	11.305
2506	SOCIAL SERVICES-OPERATING	11.305
2507	SOCIAL SERVICES-OPERATING	11.305
2508	SOCIAL SERVICES-OPERATING	11.305
2509	SOCIAL SERVICES-OPERATING	11.305
2510	SOCIAL SERVICES-OPERATING	11.305
2511	SOCIAL SERVICES-OPERATING	11.310
2512	SOCIAL SERVICES-OPERATING	11.310
2513	SOCIAL SERVICES-OPERATING	11.315
2514	SOCIAL SERVICES-OPERATING	11.315
2515	SOCIAL SERVICES-OPERATING	11.315
2516	SOCIAL SERVICES-OPERATING	11.315
2517	SOCIAL SERVICES-OPERATING	11.315
2518	SOCIAL SERVICES-OPERATING	11.320
2519	SOCIAL SERVICES-OPERATING	11.320
2520	SOCIAL SERVICES-OPERATING	11.325
2521	SOCIAL SERVICES-OPERATING	11.325
2522	SOCIAL SERVICES-OPERATING	11.325
2523	SOCIAL SERVICES-OPERATING	11.325
2524	SOCIAL SERVICES-OPERATING	11.325
2525	SOCIAL SERVICES-OPERATING	11.325
2526	SOCIAL SERVICES-OPERATING	11.330
2527	SOCIAL SERVICES-OPERATING	11.335
2528	SOCIAL SERVICES-OPERATING	11.335
2529	SOCIAL SERVICES-OPERATING	11.335
2530	SOCIAL SERVICES-OPERATING	11.340
2531	SOCIAL SERVICES-OPERATING	11.340
2532	SOCIAL SERVICES-OPERATING	11.345
2533	SOCIAL SERVICES-OPERATING	11.345
2534	SOCIAL SERVICES-OPERATING	11.345
2535	SOCIAL SERVICES-OPERATING	11.350
2536	SOCIAL SERVICES-OPERATING	11.350
2537	SOCIAL SERVICES-OPERATING	11.350
2538	SOCIAL SERVICES-OPERATING	11.350
2539	SOCIAL SERVICES-OPERATING	11.350
2540	SOCIAL SERVICES-OPERATING	11.350
2541	SOCIAL SERVICES-OPERATING	11.350
2542	SOCIAL SERVICES-OPERATING	11.350
2543	SOCIAL SERVICES-OPERATING	11.355
2544	SOCIAL SERVICES-OPERATING	11.355
2545	SOCIAL SERVICES-OPERATING	11.360
2546	SOCIAL SERVICES-OPERATING	11.360
2547	SOCIAL SERVICES-OPERATING	11.360
2548	SOCIAL SERVICES-OPERATING	11.365
2549	SOCIAL SERVICES-OPERATING	11.370
2550	SOCIAL SERVICES-OPERATING	11.375
2551	SOCIAL SERVICES-OPERATING	11.380
2552	SOCIAL SERVICES-OPERATING	11.385

Exhibit A

#	Agnecy	Budget Appropriation Line
2553	SOCIAL SERVICES-OPERATING	11.385
2554	SOCIAL SERVICES-OPERATING	11.385
2555	SOCIAL SERVICES-OPERATING	11.385
2556	SOCIAL SERVICES-OPERATING	11.385
2557	SOCIAL SERVICES-OPERATING	11.385
2558	SOCIAL SERVICES-OPERATING	11.385
2559	SOCIAL SERVICES-OPERATING	11.400
2560	SOCIAL SERVICES-OPERATING	11.400
2561	SOCIAL SERVICES-OPERATING	11.400
2562	SOCIAL SERVICES-OPERATING	11.400
2563	SOCIAL SERVICES-OPERATING	11.400
2564	SOCIAL SERVICES-OPERATING	11.405
2565	SOCIAL SERVICES-OPERATING	11.405
2566	SOCIAL SERVICES-OPERATING	11.405
2567	SOCIAL SERVICES-OPERATING	11.405
2568	SOCIAL SERVICES-OPERATING	11.405
2569	SOCIAL SERVICES-OPERATING	11.405
2570	SOCIAL SERVICES-OPERATING	11.405
2571	SOCIAL SERVICES-OPERATING	11.405
2572	SOCIAL SERVICES-OPERATING	11.405
2573	SOCIAL SERVICES-OPERATING	11.405
2574	SOCIAL SERVICES-OPERATING	11.405
2575	SOCIAL SERVICES-OPERATING	11.410
2576	SOCIAL SERVICES-OPERATING	11.410
2577	SOCIAL SERVICES-OPERATING	11.600
2578	SOCIAL SERVICES-OPERATING	11.600
2579	SOCIAL SERVICES-OPERATING	11.600
2580	SOCIAL SERVICES-OPERATING	11.600
2581	SOCIAL SERVICES-OPERATING	11.600
2582	SOCIAL SERVICES-OPERATING	11.600
2583	SOCIAL SERVICES-OPERATING	11.600
2584	SOCIAL SERVICES-OPERATING	11.600
2585	SOCIAL SERVICES-OPERATING	11.600
2586	SOCIAL SERVICES-OPERATING	11.600
2587	SOCIAL SERVICES-OPERATING	11.600
2588	SOCIAL SERVICES-OPERATING	11.600
2589	SOCIAL SERVICES-OPERATING	11.600
2590	SOCIAL SERVICES-OPERATING	11.600
2591	SOCIAL SERVICES-OPERATING	11.600
2592	SOCIAL SERVICES-OPERATING	11.600
2593	SOCIAL SERVICES-OPERATING	11.600
2594	SOCIAL SERVICES-OPERATING	11.600
2595	SOCIAL SERVICES-OPERATING	11.600
2596	SOCIAL SERVICES-OPERATING	11.600
2597	SOCIAL SERVICES-OPERATING	11.600
2598	SOCIAL SERVICES-OPERATING	11.600
2599	SOCIAL SERVICES-OPERATING	11.605
2600	SOCIAL SERVICES-OPERATING	11.605
2601	SOCIAL SERVICES-OPERATING	11.605
2602	SOCIAL SERVICES-OPERATING	11.605
2603	SOCIAL SERVICES-OPERATING	11.605
2604	SOCIAL SERVICES-OPERATING	11.606
2605	SOCIAL SERVICES-OPERATING	11.606
2606	SOCIAL SERVICES-OPERATING	11.606
2607	SOCIAL SERVICES-OPERATING	11.606
2608	SOCIAL SERVICES-OPERATING	11.610
2609	SOCIAL SERVICES-OPERATING	11.610
2610	SOCIAL SERVICES-OPERATING	11.615

Exhibit A

#	Agnecy	Budget Appropriation Line
2611	SOCIAL SERVICES-OPERATING	11.615
2612	SOCIAL SERVICES-OPERATING	11.615
2613	SOCIAL SERVICES-OPERATING	11.615
2614	SOCIAL SERVICES-OPERATING	11.615
2615	SOCIAL SERVICES-OPERATING	11.620
2616	SOCIAL SERVICES-OPERATING	11.621
2617	SOCIAL SERVICES-OPERATING	11.621
2618	SOCIAL SERVICES-OPERATING	11.622
2619	SOCIAL SERVICES-OPERATING	11.622
2620	SOCIAL SERVICES-OPERATING	11.625
2621	SOCIAL SERVICES-OPERATING	11.630
2622	SOCIAL SERVICES-OPERATING	11.630
2623	SOCIAL SERVICES-OPERATING	11.630
2624	SOCIAL SERVICES-OPERATING	11.630
2625	SOCIAL SERVICES-OPERATING	11.630
2626	SOCIAL SERVICES-OPERATING	11.630
2627	SOCIAL SERVICES-OPERATING	11.630
2628	SOCIAL SERVICES-OPERATING	11.635
2629	SOCIAL SERVICES-OPERATING	11.635
2630	SOCIAL SERVICES-OPERATING	11.640
2631	SOCIAL SERVICES-OPERATING	11.645
2632	SOCIAL SERVICES-OPERATING	11.645
2633	SOCIAL SERVICES-OPERATING	11.645
2634	SOCIAL SERVICES-OPERATING	11.645
2635	SOCIAL SERVICES-OPERATING	11.645
2636	SOCIAL SERVICES-OPERATING	11.645
2637	SOCIAL SERVICES-OPERATING	11.645
2638	SOCIAL SERVICES-OPERATING	11.645
2639	SOCIAL SERVICES-OPERATING	11.645
2640	SOCIAL SERVICES-OPERATING	11.645
2641	SOCIAL SERVICES-OPERATING	11.650
2642	SOCIAL SERVICES-OPERATING	11.650
2643	SOCIAL SERVICES-OPERATING	11.650
2644	SOCIAL SERVICES-OPERATING	11.655
2645	SOCIAL SERVICES-OPERATING	11.660
2646	SOCIAL SERVICES-OPERATING	11.660
2647	SOCIAL SERVICES-OPERATING	11.660
2648	SOCIAL SERVICES-OPERATING	11.660
2649	SOCIAL SERVICES-OPERATING	11.660
2650	SOCIAL SERVICES-OPERATING	11.665
2651	SOCIAL SERVICES-OPERATING	11.670
2652	SOCIAL SERVICES-OPERATING	11.670
2653	SOCIAL SERVICES-OPERATING	11.675
2654	SOCIAL SERVICES-OPERATING	11.675
2655	SOCIAL SERVICES-OPERATING	11.675
2656	SOCIAL SERVICES-OPERATING	11.675
2657	SOCIAL SERVICES-OPERATING	11.675
2658	SOCIAL SERVICES-OPERATING	11.675
2659	SOCIAL SERVICES-OPERATING	11.675
2660	SOCIAL SERVICES-OPERATING	11.675
2661	SOCIAL SERVICES-OPERATING	11.675
2662	SOCIAL SERVICES-OPERATING	11.675
2663	SOCIAL SERVICES-OPERATING	11.680
2664	SOCIAL SERVICES-OPERATING	11.680
2665	SOCIAL SERVICES-OPERATING	11.685
2666	SOCIAL SERVICES-OPERATING	11.685
2667	SOCIAL SERVICES-OPERATING	11.690
2668	SOCIAL SERVICES-OPERATING	11.690

Exhibit A

#	Agnecy	Budget Appropriation Line
2669	SOCIAL SERVICES-OPERATING	11.690
2670	SOCIAL SERVICES-OPERATING	11.690
2671	SOCIAL SERVICES-OPERATING	11.690
2672	SOCIAL SERVICES-OPERATING	11.690
2673	SOCIAL SERVICES-OPERATING	11.690
2674	SOCIAL SERVICES-OPERATING	11.690
2675	SOCIAL SERVICES-OPERATING	11.690
2676	SOCIAL SERVICES-OPERATING	11.690
2677	SOCIAL SERVICES-OPERATING	11.690
2678	SOCIAL SERVICES-OPERATING	11.690
2679	SOCIAL SERVICES-OPERATING	11.690
2680	SOCIAL SERVICES-OPERATING	11.690
2681	SOCIAL SERVICES-OPERATING	11.690
2682	SOCIAL SERVICES-OPERATING	11.695
2683	SOCIAL SERVICES-OPERATING	11.695
2684	SOCIAL SERVICES-OPERATING	11.695
2685	SOCIAL SERVICES-OPERATING	11.695
2686	SOCIAL SERVICES-OPERATING	11.695
2687	SOCIAL SERVICES-OPERATING	11.695
2688	SOCIAL SERVICES-OPERATING	11.695
2689	SOCIAL SERVICES-OPERATING	11.695
2690	SOCIAL SERVICES-OPERATING	11.695
2691	SOCIAL SERVICES-OPERATING	11.695
2692	SOCIAL SERVICES-OPERATING	11.695
2693	SOCIAL SERVICES-OPERATING	11.695
2694	SOCIAL SERVICES-OPERATING	11.700
2695	SOCIAL SERVICES-OPERATING	11.705
2696	SOCIAL SERVICES-OPERATING	11.705
2697	SOCIAL SERVICES-OPERATING	11.705
2698	SOCIAL SERVICES-OPERATING	11.705
2699	SOCIAL SERVICES-OPERATING	11.705
2700	SOCIAL SERVICES-OPERATING	11.706
2701	SOCIAL SERVICES-OPERATING	11.706
2702	SOCIAL SERVICES-OPERATING	11.710
2703	SOCIAL SERVICES-OPERATING	11.710
2704	SOCIAL SERVICES-OPERATING	11.710
2705	SOCIAL SERVICES-OPERATING	11.715
2706	SOCIAL SERVICES-OPERATING	11.715
2707	SOCIAL SERVICES-OPERATING	11.720
2708	SOCIAL SERVICES-OPERATING	11.720
2709	SOCIAL SERVICES-OPERATING	11.725
2710	SOCIAL SERVICES-OPERATING	11.725
2711	SOCIAL SERVICES-OPERATING	11.730
2712	SOCIAL SERVICES-OPERATING	11.730
2713	SOCIAL SERVICES-OPERATING	11.730
2714	SOCIAL SERVICES-OPERATING	11.730
2715	SOCIAL SERVICES-OPERATING	11.735
2716	SOCIAL SERVICES-OPERATING	11.740
2717	SOCIAL SERVICES-OPERATING	11.743
2718	SOCIAL SERVICES-OPERATING	11.745
2719	SOCIAL SERVICES-OPERATING	11.750
2720	SOCIAL SERVICES-OPERATING	11.750
2721	SOCIAL SERVICES-OPERATING	11.760
2722	SOCIAL SERVICES-OPERATING	11.770
2723	SOCIAL SERVICES-OPERATING	11.780
2724	SOCIAL SERVICES-OPERATING	11.790
2725	SOCIAL SERVICES-OPERATING	11.795
2726	SOCIAL SERVICES-OPERATING	11.800

Exhibit A

#	Agnecy	Budget Appropriation Line
2727	GOVERNOR-OPERATING	12.005
2728	GOVERNOR-OPERATING	12.005
2729	GOVERNOR-OPERATING	12.005
2730	GOVERNOR-OPERATING	12.005
2731	GOVERNOR-OPERATING	12.005
2732	GOVERNOR-OPERATING	12.005
2733	GOVERNOR-OPERATING	12.005
2734	GOVERNOR-OPERATING	12.005
2735	GOVERNOR-OPERATING	12.005
2736	GOVERNOR-OPERATING	12.005
2737	GOVERNOR-OPERATING	12.005
2738	GOVERNOR-OPERATING	12.005
2739	GOVERNOR-OPERATING	12.005
2740	GOVERNOR-OPERATING	12.005
2741	GOVERNOR-OPERATING	12.005
2742	GOVERNOR-OPERATING	12.005
2743	GOVERNOR-OPERATING	12.005
2744	GOVERNOR-OPERATING	12.005
2745	GOVERNOR-OPERATING	12.005
2746	GOVERNOR-OPERATING	12.005
2747	GOVERNOR-OPERATING	12.005
2748	GOVERNOR-OPERATING	12.005
2749	GOVERNOR-OPERATING	12.006
2750	LT. GOVERNOR-OPERATING	12.025
2751	LT. GOVERNOR-OPERATING	12.026
2752	LT. GOVERNOR-OPERATING	12.026
2753	LT. GOVERNOR-OPERATING	12.030
2754	LT. GOVERNOR-OPERATING	12.030
2755	LT. GOVERNOR-OPERATING	12.030
2756	LT. GOVERNOR-OPERATING	12.030
2757	LT. GOVERNOR-OPERATING	12.030
2758	LT. GOVERNOR-OPERATING	12.030
2759	LT. GOVERNOR-OPERATING	12.030
2760	LT. GOVERNOR-OPERATING	12.030
2761	LT. GOVERNOR-OPERATING	12.035
2762	LT. GOVERNOR-OPERATING	12.040
2763	LT. GOVERNOR-OPERATING	12.045
2764	SECRETARY OF STATE-OPER	12.055
2765	SECRETARY OF STATE-OPER	12.055
2766	SECRETARY OF STATE-OPER	12.055
2767	SECRETARY OF STATE-OPER	12.055
2768	SECRETARY OF STATE-OPER	12.055
2769	SECRETARY OF STATE-OPER	12.055
2770	SECRETARY OF STATE-OPER	12.055
2771	SECRETARY OF STATE-OPER	12.055
2772	SECRETARY OF STATE-OPER	12.055
2773	SECRETARY OF STATE-OPER	12.055
2774	SECRETARY OF STATE-OPER	12.055
2775	SECRETARY OF STATE-OPER	12.056
2776	SECRETARY OF STATE-OPER	12.056
2777	SECRETARY OF STATE-OPER	12.060
2778	SECRETARY OF STATE-OPER	12.065
2779	SECRETARY OF STATE-OPER	12.070
2780	SECRETARY OF STATE-OPER	12.070
2781	SECRETARY OF STATE-OPER	12.075
2782	SECRETARY OF STATE-OPER	12.080
2783	SECRETARY OF STATE-OPER	12.090
2784	SECRETARY OF STATE-OPER	12.090

Exhibit A

#	Agnecy	Budget Appropriation Line
2785	SECRETARY OF STATE-OPER	12.090
2786	SECRETARY OF STATE-OPER	12.100
2787	SECRETARY OF STATE-OPER	12.105
2788	SECRETARY OF STATE-OPER	12.110
2789	SECRETARY OF STATE-OPER	12.115
2790	SECRETARY OF STATE-OPER	12.125
2791	SECRETARY OF STATE-OPER	12.130
2792	SECRETARY OF STATE-OPER	12.135
2793	SECRETARY OF STATE-OPER	12.140
2794	STATE AUDITOR-OPERATING	12.165
2795	STATE AUDITOR-OPERATING	12.165
2796	STATE AUDITOR-OPERATING	12.165
2797	STATE AUDITOR-OPERATING	12.165
2798	STATE AUDITOR-OPERATING	12.165
2799	STATE AUDITOR-OPERATING	12.165
2800	STATE AUDITOR-OPERATING	12.165
2801	STATE AUDITOR-OPERATING	12.165
2802	STATE AUDITOR-OPERATING	12.165
2803	STATE AUDITOR-OPERATING	12.166
2804	STATE AUDITOR-OPERATING	12.166
2805	STATE TREASURER-OPERATING	12.185
2806	STATE TREASURER-OPERATING	12.185
2807	STATE TREASURER-OPERATING	12.185
2808	STATE TREASURER-OPERATING	12.185
2809	STATE TREASURER-OPERATING	12.185
2810	STATE TREASURER-OPERATING	12.185
2811	STATE TREASURER-OPERATING	12.185
2812	STATE TREASURER-OPERATING	12.185
2813	STATE TREASURER-OPERATING	12.186
2814	STATE TREASURER-OPERATING	12.195
2815	STATE TREASURER-OPERATING	12.200
2816	STATE TREASURER-OPERATING	12.205
2817	STATE TREASURER-OPERATING	12.215
2818	STATE TREASURER-OPERATING	12.220
2819	STATE TREASURER-OPERATING	12.225
2820	ATTORNEY GENERAL-OPER	12.245
2821	ATTORNEY GENERAL-OPER	12.245
2822	ATTORNEY GENERAL-OPER	12.245
2823	ATTORNEY GENERAL-OPER	12.245
2824	ATTORNEY GENERAL-OPER	12.245
2825	ATTORNEY GENERAL-OPER	12.245
2826	ATTORNEY GENERAL-OPER	12.245
2827	ATTORNEY GENERAL-OPER	12.245
2828	ATTORNEY GENERAL-OPER	12.245
2829	ATTORNEY GENERAL-OPER	12.245
2830	ATTORNEY GENERAL-OPER	12.245
2831	ATTORNEY GENERAL-OPER	12.245
2832	ATTORNEY GENERAL-OPER	12.245
2833	ATTORNEY GENERAL-OPER	12.245
2834	ATTORNEY GENERAL-OPER	12.245
2835	ATTORNEY GENERAL-OPER	12.245
2836	ATTORNEY GENERAL-OPER	12.245
2837	ATTORNEY GENERAL-OPER	12.245
2838	ATTORNEY GENERAL-OPER	12.245
2839	ATTORNEY GENERAL-OPER	12.245
2840	ATTORNEY GENERAL-OPER	12.245
2841	ATTORNEY GENERAL-OPER	12.245
2842	ATTORNEY GENERAL-OPER	12.245

Exhibit A

#	Agnecy	Budget Appropriation Line
2843	ATTORNEY GENERAL-OPER	12.245
2844	ATTORNEY GENERAL-OPER	12.245
2845	ATTORNEY GENERAL-OPER	12.245
2846	ATTORNEY GENERAL-OPER	12.245
2847	ATTORNEY GENERAL-OPER	12.245
2848	ATTORNEY GENERAL-OPER	12.245
2849	ATTORNEY GENERAL-OPER	12.245
2850	ATTORNEY GENERAL-OPER	12.245
2851	ATTORNEY GENERAL-OPER	12.245
2852	ATTORNEY GENERAL-OPER	12.245
2853	ATTORNEY GENERAL-OPER	12.245
2854	ATTORNEY GENERAL-OPER	12.246
2855	ATTORNEY GENERAL-OPER	12.246
2856	ATTORNEY GENERAL-OPER	12.250
2857	ATTORNEY GENERAL-OPER	12.255
2858	ATTORNEY GENERAL-OPER	12.255
2859	ATTORNEY GENERAL-OPER	12.255
2860	ATTORNEY GENERAL-OPER	12.255
2861	ATTORNEY GENERAL-OPER	12.260
2862	ATTORNEY GENERAL-OPER	12.260
2863	ATTORNEY GENERAL-OPER	12.260
2864	ATTORNEY GENERAL-OPER	12.260
2865	ATTORNEY GENERAL-OPER	12.260
2866	ATTORNEY GENERAL-OPER	12.260
2867	ATTORNEY GENERAL-OPER	12.260
2868	ATTORNEY GENERAL-OPER	12.260
2869	ATTORNEY GENERAL-OPER	12.265
2870	ATTORNEY GENERAL-OPER	12.270
2871	JUDICIARY-OPERATING	12.300
2872	JUDICIARY-OPERATING	12.300
2873	JUDICIARY-OPERATING	12.301
2874	JUDICIARY-OPERATING	12.302
2875	JUDICIARY-OPERATING	12.302
2876	JUDICIARY-OPERATING	12.305
2877	JUDICIARY-OPERATING	12.305
2878	JUDICIARY-OPERATING	12.305
2879	JUDICIARY-OPERATING	12.310
2880	JUDICIARY-OPERATING	12.310
2881	JUDICIARY-OPERATING	12.310
2882	JUDICIARY-OPERATING	12.310
2883	JUDICIARY-OPERATING	12.310
2884	JUDICIARY-OPERATING	12.315
2885	JUDICIARY-OPERATING	12.315
2886	JUDICIARY-OPERATING	12.325
2887	JUDICIARY-OPERATING	12.325
2888	JUDICIARY-OPERATING	12.325
2889	JUDICIARY-OPERATING	12.336
2890	JUDICIARY-OPERATING	12.336
2891	JUDICIARY-OPERATING	12.336
2892	JUDICIARY-OPERATING	12.340
2893	JUDICIARY-OPERATING	12.340
2894	JUDICIARY-OPERATING	12.340
2895	JUDICIARY-OPERATING	12.340
2896	JUDICIARY-OPERATING	12.340
2897	JUDICIARY-OPERATING	12.340
2898	JUDICIARY-OPERATING	12.340
2899	JUDICIARY-OPERATING	12.340
2900	JUDICIARY-OPERATING	12.341

Exhibit A

#	Agnecy	Budget Appropriation Line
2901	JUDICIARY-OPERATING	12.345
2902	JUDICIARY-OPERATING	12.350
2903	JUDICIARY-OPERATING	12.370
2904	JUDICIARY-OPERATING	12.370
2905	JUDICIARY-OPERATING	12.370
2906	PUBLIC DEFENDER-OPERATING	12.400
2907	PUBLIC DEFENDER-OPERATING	12.400
2908	PUBLIC DEFENDER-OPERATING	12.400
2909	PUBLIC DEFENDER-OPERATING	12.400
2910	PUBLIC DEFENDER-OPERATING	12.400
2911	PUBLIC DEFENDER-OPERATING	12.401
2912	LEGISLATURE-OPERATING	12.500
2913	LEGISLATURE-OPERATING	12.505
2914	LEGISLATURE-OPERATING	12.520
2915	AGRICULTURE-LEASING	13.005
2916	MENTAL HEALTH-LEASING	13.005
2917	ELEM & SEC EDUCATION-LEAS	13.005
2918	ELEM & SEC EDUCATION-LEAS	13.005
2919	ELEM & SEC EDUCATION-LEAS	13.005
2920	OFFICE ADMINISTRATION-LEAS	13.005
2921	OFFICE ADMINISTRATION-LEAS	13.005
2922	OFFICE ADMINISTRATION-LEAS	13.005
2923	CORRECTIONS-LEASING	13.005
2924	PUBLIC SAFETY-LEASING	13.005
2925	SOCIAL SERVICES-LEASING	13.005
2926	SOCIAL SERVICES-LEASING	13.005
2927	AGRICULTURE-LEASING	13.005
2928	AGRICULTURE-LEASING	13.005
2929	ECONOMIC DEVELOPMENT-LEAS	13.005
2930	ATTORNEY GENERAL-LEASING	13.005
2931	PUBLIC SAFETY-LEASING	13.005
2932	ATTORNEY GENERAL-LEASING	13.005
2933	LABOR & INDUSTRIAL REL-LEAS	13.005
2934	ELEM & SEC EDUCATION-LEAS	13.005
2935	ELEM & SEC EDUCATION-LEAS	13.005
2936	LABOR & INDUSTRIAL REL-LEAS	13.005
2937	NATURAL RESOURCES-LEASING	13.005
2938	ATTORNEY GENERAL-LEASING	13.005
2939	ATTORNEY GENERAL-LEASING	13.005
2940	ATTORNEY GENERAL-LEASING	13.005
2941	ATTORNEY GENERAL-LEASING	13.005
2942	ATTORNEY GENERAL-LEASING	13.005
2943	STATE AUDITOR-LEASING	13.005
2944	PUBLIC SAFETY-LEASING	13.005
2945	PUBLIC SAFETY-LEASING	13.005
2946	PUBLIC SAFETY-LEASING	13.005
2947	LABOR & INDUSTRIAL REL-LEAS	13.005
2948	LABOR & INDUSTRIAL REL-LEAS	13.005
2949	LABOR & INDUSTRIAL REL-LEAS	13.005
2950	OFFICE ADMINISTRATION-LEAS	13.005
2951	REVENUE-LEASING	13.005
2952	DCI-LEASING	13.005
2953	DCI-LEASING	13.005
2954	DCI-LEASING	13.005
2955	HEALTH & SENIOR SERVICES-LEAS	13.005
2956	HEALTH & SENIOR SERVICES-LEAS	13.005
2957	PUBLIC SAFETY-LEASING	13.005
2958	AGRICULTURE-LEASING	13.005

Exhibit A

#	Agnecy	Budget Appropriation Line
2959	NATURAL RESOURCES-LEASING	13.005
2960	NATURAL RESOURCES-LEASING	13.005
2961	NATURAL RESOURCES-LEASING	13.005
2962	NATURAL RESOURCES-LEASING	13.005
2963	NATURAL RESOURCES-LEASING	13.005
2964	NATURAL RESOURCES-LEASING	13.005
2965	NATURAL RESOURCES-LEASING	13.005
2966	NATURAL RESOURCES-LEASING	13.005
2967	NATURAL RESOURCES-LEASING	13.005
2968	NATURAL RESOURCES-LEASING	13.005
2969	NATURAL RESOURCES-LEASING	13.005
2970	NATURAL RESOURCES-LEASING	13.005
2971	NATURAL RESOURCES-LEASING	13.005
2972	DCI-LEASING	13.005
2973	DCI-LEASING	13.005
2974	LT. GOVERNOR-LEASING	13.005
2975	LT. GOVERNOR-LEASING	13.005
2976	DHEWD-LEASING	13.005
2977	DHEWD-LEASING	13.005
2978	NATURAL RESOURCES-LEASING	13.005
2979	CORRECTIONS-LEASING	13.005
2980	SECRETARY OF STATE-LEASING	13.005
2981	SECRETARY OF STATE-LEASING	13.005
2982	DCI-LEASING	13.005
2983	JUDICIARY-LEASING	13.005
2984	JUDICIARY-LEASING	13.005
2985	JUDICIARY-LEASING	13.005
2986	REVENUE-LEASING	13.005
2987	NATURAL RESOURCES-LEASING	13.005
2988	NATURAL RESOURCES-LEASING	13.005
2989	ELEM & SEC EDUCATION-LEAS	13.005
2990	PUBLIC SAFETY-LEASING	13.005
2991	LEGISLATURE-LEASING	13.005
2992	PUBLIC SAFETY-LEASING	13.005
2993	PUBLIC SAFETY-LEASING	13.005
2994	AGRICULTURE-LEASING	13.005
2995	PUBLIC SAFETY-LEASING	13.005
2996	GOVERNOR-LEASING	13.010
2997	LT. GOVERNOR-LEASING	13.010
2998	NATURAL RESOURCES-LEASING	13.010
2999	NATURAL RESOURCES-LEASING	13.010
3000	NATURAL RESOURCES-LEASING	13.010
3001	NATURAL RESOURCES-LEASING	13.010
3002	NATURAL RESOURCES-LEASING	13.010
3003	NATURAL RESOURCES-LEASING	13.010
3004	NATURAL RESOURCES-LEASING	13.010
3005	NATURAL RESOURCES-LEASING	13.010
3006	NATURAL RESOURCES-LEASING	13.010
3007	NATURAL RESOURCES-LEASING	13.010
3008	NATURAL RESOURCES-LEASING	13.010
3009	NATURAL RESOURCES-LEASING	13.010
3010	NATURAL RESOURCES-LEASING	13.010
3011	PUBLIC SAFETY-LEASING	13.010
3012	DHEWD-LEASING	13.010
3013	NATURAL RESOURCES-LEASING	13.010
3014	NATURAL RESOURCES-LEASING	13.010
3015	DCI-LEASING	13.010
3016	ELEM & SEC EDUCATION-LEAS	13.010

Exhibit A

#	Agnecy	Budget Appropriation Line
3017	ELEM & SEC EDUCATION-LEAS	13.010
3018	ELEM & SEC EDUCATION-LEAS	13.010
3019	REVENUE-LEASING	13.010
3020	OFFICE ADMINISTRATION-LEAS	13.010
3021	OFFICE ADMINISTRATION-LEAS	13.010
3022	OFFICE ADMINISTRATION-LEAS	13.010
3023	AGRICULTURE-LEASING	13.010
3024	AGRICULTURE-LEASING	13.010
3025	AGRICULTURE-LEASING	13.010
3026	AGRICULTURE-LEASING	13.010
3027	AGRICULTURE-LEASING	13.010
3028	AGRICULTURE-LEASING	13.010
3029	AGRICULTURE-LEASING	13.010
3030	AGRICULTURE-LEASING	13.010
3031	AGRICULTURE-LEASING	13.010
3032	NATURAL RESOURCES-LEASING	13.010
3033	NATURAL RESOURCES-LEASING	13.010
3034	NATURAL RESOURCES-LEASING	13.010
3035	ECONOMIC DEVELOPMENT-LEAS	13.010
3036	ECONOMIC DEVELOPMENT-LEAS	13.010
3037	ECONOMIC DEVELOPMENT-LEAS	13.010
3038	DCI-LEASING	13.010
3039	DCI-LEASING	13.010
3040	DCI-LEASING	13.010
3041	DCI-LEASING	13.010
3042	DCI-LEASING	13.010
3043	LABOR & INDUSTRIAL REL-LEAS	13.010
3044	LABOR & INDUSTRIAL REL-LEAS	13.010
3045	LABOR & INDUSTRIAL REL-LEAS	13.010
3046	LABOR & INDUSTRIAL REL-LEAS	13.010
3047	LABOR & INDUSTRIAL REL-LEAS	13.010
3048	LABOR & INDUSTRIAL REL-LEAS	13.010
3049	LABOR & INDUSTRIAL REL-LEAS	13.010
3050	PUBLIC SAFETY-LEASING	13.010
3051	PUBLIC SAFETY-LEASING	13.010
3052	CORRECTIONS-LEASING	13.010
3053	MENTAL HEALTH-LEASING	13.010
3054	MENTAL HEALTH-LEASING	13.010
3055	MENTAL HEALTH-LEASING	13.010
3056	MENTAL HEALTH-LEASING	13.010
3057	HEALTH & SENIOR SERVICES-LEAS	13.010
3058	HEALTH & SENIOR SERVICES-LEAS	13.010
3059	SOCIAL SERVICES-LEASING	13.010
3060	SOCIAL SERVICES-LEASING	13.010
3061	SOCIAL SERVICES-LEASING	13.010
3062	SOCIAL SERVICES-LEASING	13.010
3063	SOCIAL SERVICES-LEASING	13.010
3064	LEGISLATURE-LEASING	13.010
3065	SECRETARY OF STATE-LEASING	13.010
3066	SECRETARY OF STATE-LEASING	13.010
3067	SECRETARY OF STATE-LEASING	13.010
3068	SECRETARY OF STATE-LEASING	13.010
3069	STATE AUDITOR-LEASING	13.010
3070	ATTORNEY GENERAL-LEASING	13.010
3071	ATTORNEY GENERAL-LEASING	13.010
3072	ATTORNEY GENERAL-LEASING	13.010
3073	ATTORNEY GENERAL-LEASING	13.010
3074	ATTORNEY GENERAL-LEASING	13.010

Exhibit A

#	Agnecy	Budget Appropriation Line
3075	ATTORNEY GENERAL-LEASING	13.010
3076	STATE TREASURER-LEASING	13.010
3077	JUDICIARY-LEASING	13.010
3078	AGRICULTURE-LEASING	13.010
3079	DHEWD-LEASING	13.010
3080	PUBLIC SAFETY-LEASING	13.010
3081	AGRICULTURE-LEASING	13.010
3082	PUBLIC SAFETY-LEASING	13.010
3083	AGRICULTURE-LEASING	13.010
3084	PUBLIC SAFETY-LEASING	13.010
3085	HEALTH & SENIOR SERVICES-LEAS	13.015
3086	ELEM & SEC EDUCATION-LEAS	13.015
3087	PUBLIC SAFETY-LEASING	13.015
3088	PUBLIC SAFETY-LEASING	13.015
3089	MENTAL HEALTH-LEASING	13.015
3090	SOCIAL SERVICES-LEASING	13.015
3091	SOCIAL SERVICES-LEASING	13.015
3092	HEALTH & SENIOR SERVICES-LEAS	13.015
3093	OFFICE ADMINISTRATION-LEAS	13.020
3094	OFFICE ADMINISTRATION-LEAS	13.020
3095	OFFICE ADMINISTRATION-LEAS	13.020
3096	OFFICE ADMINISTRATION-LEAS	13.021
3097	ELEM & SEC EDUCATION-CI	17.005
3098	ELEM & SEC EDUCATION-CI	17.010
3099	DHEWD-CI	17.025
3100	DHEWD-CI	17.030
3101	DHEWD-CI	17.040
3102	DHEWD-CI	17.045
3103	DHEWD-CI	17.050
3104	DHEWD-CI	17.055
3105	DHEWD-CI	17.060
3106	DHEWD-CI	17.065
3107	DHEWD-CI	17.070
3108	DHEWD-CI	17.075
3109	DHEWD-CI	17.080
3110	OFFICE ADMINISTRATION-CI	17.085
3111	OFFICE ADMINISTRATION-CI	17.090
3112	OFFICE ADMINISTRATION-CI	17.095
3113	OFFICE ADMINISTRATION-CI	17.100
3114	OFFICE ADMINISTRATION-CI	17.100
3115	OFFICE ADMINISTRATION-CI	17.100
3116	OFFICE ADMINISTRATION-CI	17.100
3117	AGRICULTURE-CI	17.105
3118	AGRICULTURE-CI	17.110
3119	NATURAL RESOURCES-CI	17.115
3120	NATURAL RESOURCES-CI	17.120
3121	NATURAL RESOURCES-CI	17.125
3122	NATURAL RESOURCES-CI	17.130
3123	NATURAL RESOURCES-CI	17.135
3124	NATURAL RESOURCES-CI	17.140
3125	NATURAL RESOURCES-CI	17.145
3126	NATURAL RESOURCES-CI	17.150
3127	NATURAL RESOURCES-CI	17.150
3128	NATURAL RESOURCES-CI	17.150
3129	NATURAL RESOURCES-CI	17.150
3130	NATURAL RESOURCES-CI	17.150
3131	NATURAL RESOURCES-CI	17.150
3132	NATURAL RESOURCES-CI	17.155

Exhibit A

#	Agnecy	Budget Appropriation Line
3133	NATURAL RESOURCES-CI	17.155
3134	NATURAL RESOURCES-CI	17.155
3135	NATURAL RESOURCES-CI	17.155
3136	NATURAL RESOURCES-CI	17.155
3137	NATURAL RESOURCES-CI	17.155
3138	NATURAL RESOURCES-CI	17.155
3139	NATURAL RESOURCES-CI	17.160
3140	NATURAL RESOURCES-CI	17.160
3141	NATURAL RESOURCES-CI	17.160
3142	NATURAL RESOURCES-CI	17.160
3143	NATURAL RESOURCES-CI	17.160
3144	NATURAL RESOURCES-CI	17.160
3145	NATURAL RESOURCES-CI	17.160
3146	NATURAL RESOURCES-CI	17.160
3147	NATURAL RESOURCES-CI	17.160
3148	NATURAL RESOURCES-CI	17.165
3149	NATURAL RESOURCES-CI	17.170
3150	NATURAL RESOURCES-CI	17.170
3151	NATURAL RESOURCES-CI	17.170
3152	NATURAL RESOURCES-CI	17.170
3153	NATURAL RESOURCES-CI	17.175
3154	NATURAL RESOURCES-CI	17.180
3155	CONSERVATION-CI	17.185
3156	CONSERVATION-CI	17.190
3157	LABOR & INDUSTRIAL REL-CI	17.195
3158	LABOR & INDUSTRIAL REL-CI	17.200
3159	LABOR & INDUSTRIAL REL-CI	17.200
3160	PUBLIC SAFETY-CI	17.205
3161	PUBLIC SAFETY-CI	17.205
3162	PUBLIC SAFETY-CI	17.205
3163	PUBLIC SAFETY-CI	17.210
3164	PUBLIC SAFETY-CI	17.215
3165	PUBLIC SAFETY-CI	17.220
3166	PUBLIC SAFETY-CI	17.220
3167	PUBLIC SAFETY-CI	17.225
3168	PUBLIC SAFETY-CI	17.225
3169	PUBLIC SAFETY-CI	17.225
3170	PUBLIC SAFETY-CI	17.225
3171	PUBLIC SAFETY-CI	17.230
3172	PUBLIC SAFETY-CI	17.230
3173	PUBLIC SAFETY-CI	17.235
3174	PUBLIC SAFETY-CI	17.235
3175	PUBLIC SAFETY-CI	17.240
3176	PUBLIC SAFETY-CI	17.245
3177	PUBLIC SAFETY-CI	17.245
3178	PUBLIC SAFETY-CI	17.250
3179	PUBLIC SAFETY-CI	17.250
3180	PUBLIC SAFETY-CI	17.255
3181	PUBLIC SAFETY-CI	17.260
3182	PUBLIC SAFETY-CI	17.260
3183	PUBLIC SAFETY-CI	17.265
3184	PUBLIC SAFETY-CI	17.270
3185	PUBLIC SAFETY-CI	17.270
3186	PUBLIC SAFETY-CI	17.270
3187	CORRECTIONS-CI	17.275
3188	MENTAL HEALTH-CI	17.285
3189	MENTAL HEALTH-CI	17.290
3190	MENTAL HEALTH-CI	17.295

Exhibit A

#	Agnecy	Budget Appropriation Line
3191	SOCIAL SERVICES-CI	17.300
3192	SOCIAL SERVICES-CI	17.305
3193	ELEM & SEC EDUCATION-CI	18.005
3194	ELEM & SEC EDUCATION-CI	18.005
3195	ELEM & SEC EDUCATION-CI	18.005
3196	REVENUE-CI	18.010
3197	OFFICE ADMINISTRATION-CI	18.015
3198	OFFICE ADMINISTRATION-CI	18.020
3199	OFFICE ADMINISTRATION-CI	18.020
3200	OFFICE ADMINISTRATION-CI	18.020
3201	OFFICE ADMINISTRATION-CI	18.020
3202	OFFICE ADMINISTRATION-CI	18.020
3203	OFFICE ADMINISTRATION-CI	18.020
3204	OFFICE ADMINISTRATION-CI	18.020
3205	OFFICE ADMINISTRATION-CI	18.020
3206	OFFICE ADMINISTRATION-CI	18.020
3207	OFFICE ADMINISTRATION-CI	18.020
3208	OFFICE ADMINISTRATION-CI	18.020
3209	OFFICE ADMINISTRATION-CI	18.020
3210	OFFICE ADMINISTRATION-CI	18.020
3211	OFFICE ADMINISTRATION-CI	18.020
3212	OFFICE ADMINISTRATION-CI	18.020
3213	OFFICE ADMINISTRATION-CI	18.020
3214	AGRICULTURE-CI	18.025
3215	AGRICULTURE-CI	18.025
3216	AGRICULTURE-CI	18.025
3217	NATURAL RESOURCES-CI	18.030
3218	NATURAL RESOURCES-CI	18.030
3219	NATURAL RESOURCES-CI	18.035
3220	NATURAL RESOURCES-CI	18.035
3221	NATURAL RESOURCES-CI	18.035
3222	NATURAL RESOURCES-CI	18.035
3223	NATURAL RESOURCES-CI	18.035
3224	NATURAL RESOURCES-CI	18.035
3225	NATURAL RESOURCES-CI	18.035
3226	NATURAL RESOURCES-CI	18.035
3227	NATURAL RESOURCES-CI	18.035
3228	NATURAL RESOURCES-CI	18.035
3229	CONSERVATION-CI	18.040
3230	LABOR & INDUSTRIAL REL-CI	18.045
3231	LABOR & INDUSTRIAL REL-CI	18.045
3232	PUBLIC SAFETY-CI	18.050
3233	PUBLIC SAFETY-CI	18.055
3234	PUBLIC SAFETY-CI	18.055
3235	PUBLIC SAFETY-CI	18.060
3236	PUBLIC SAFETY-CI	18.060
3237	PUBLIC SAFETY-CI	18.060
3238	PUBLIC SAFETY-CI	18.060
3239	CORRECTIONS-CI	18.065
3240	CORRECTIONS-CI	18.065
3241	CORRECTIONS-CI	18.065
3242	MENTAL HEALTH-CI	18.070
3243	MENTAL HEALTH-CI	18.070
3244	MENTAL HEALTH-CI	18.070
3245	SOCIAL SERVICES-CI	18.075
3246	SOCIAL SERVICES-CI	18.075
3247	SOCIAL SERVICES-CI	18.075
3248	SOCIAL SERVICES-CI	18.075

Exhibit A

#	Agnecy	Budget Appropriation Line
3249	MO TRANSPORTATION-CI	18.080
3250	ELEM & SEC EDUCATION-CI	19.005
3251	ELEM & SEC EDUCATION-CI	19.005
3252	AGRICULTURE-CI	19.010
3253	NATURAL RESOURCES-CI	19.020
3254	NATURAL RESOURCES-CI	19.020
3255	NATURAL RESOURCES-CI	19.020
3256	NATURAL RESOURCES-CI	19.020
3257	CONSERVATION-CI	19.025
3258	PUBLIC SAFETY-CI	19.030
3259	PUBLIC SAFETY-CI	19.035
3260	PUBLIC SAFETY-CI	19.035
3261	PUBLIC SAFETY-CI	19.035
3262	PUBLIC SAFETY-CI	19.040
3263	CORRECTIONS-CI	19.045
3264	LT. GOVERNOR-CI	19.050
3265	AGRICULTURE-CI	19.070
3266	DHEWD-CI	19.095
3267	DHEWD-CI	19.105
3268	DHEWD-CI	19.110
3269	DHEWD-CI	19.115
3270	DHEWD-CI	19.120
3271	OFFICE ADMINISTRATION-CI	19.125
3272	NATURAL RESOURCES-CI	19.130
3273	NATURAL RESOURCES-CI	19.135

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety- (90-) day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 2—DEPARTMENT OF AGRICULTURE
Division 70—Plant Industries
Chapter 10—Missouri Plant Law Rules

PROPOSED RULE

2 CSR 70-10.025 Nonprofit Nursery Dealer Defined

PURPOSE: This rule defines a nonprofit nursery dealer.

(1) A nursery dealer registered with the state as a nonprofit organization overseeing membership entities which may offer nursery stock for sale. The sale of such nursery stock is limited to not more than two (2) sales events conducted in a certificate year (October 1 to September 30) for each membership entity, with each sales event lasting a maximum of two (2) days. Nonprofit nursery dealers and their membership entities shall be subject to the provisions of 263.010 to 263.180. Nonprofit nursery dealers shall submit notification to the department for each membership entity sale at least thirty (30) days prior to the sale. Notification shall include, but not be limited to, the name, contact name, address, phone number, sale location(s), and sale date(s) for the membership entity.

AUTHORITY: section 263.040, RSMo 2016. Original rule filed Oct. 22, 2019.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Department of Agriculture, ATTN: John Brunnert, PO Box 630, 1616 Missouri Boulevard, Jefferson City, MO 65102, or online at Agriculture.Mo.Gov/proposed-rules/. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 70—Plant Industries
Chapter 10—Missouri Plant Law Rules

PROPOSED AMENDMENT

2 CSR 70-10.050 Out-of-State Nurseryman to Verify Inspection-Certification. The director is amending section (1).

PURPOSE: This amendment clarifies how nurserymen shipping nursery stock into Missouri verify that their nurseries have been inspected and certified by their state plant regulatory agency.

(1) Any nurseryman of any other state, territory**,** or district of the United States desiring to ship nursery stock into Missouri shall be listed in their state certified nursery directory and this directory must be filed with the office of the Missouri state entomologist **or posted online by their state plant regulatory agency**. Nurseries in states that fail to file this directory individually must file a copy of their certificate of inspection **with the office of the Missouri state entomologist**.

AUTHORITY: section 263.040, RSMo 2016. Original rule filed Aug. 4, 1958, effective Aug. 14, 1958. Amended: Filed April 22, 1965, effective May 2, 1965. Amended: Filed March 25, 1966, effective April 4, 1966. Amended: Filed May 27, 1975, effective June 6, 1975. Refiled March 11, 1976. Rescinded: Filed Aug. 14, 1984, effective Jan. 1, 1985. Readopted: Filed Sept. 12, 1984, effective Jan. 1, 1985. Amended: Filed Oct. 22, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, ATTN: John Brunnert, PO Box 630, 1616 Missouri Boulevard, Jefferson City, MO 65102, or online at Agriculture.Mo.Gov/proposed-rules/. To be considered, comments

must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 70—Plant Industries
Chapter 10—Missouri Plant Law Rules

PROPOSED AMENDMENT

2 CSR 70-10.075 Fee Schedule. The director is amending sections (1) through (10), adding a new section (11), and renumbering the previous section (11).

PURPOSE: This amendment revises the fee schedule for inspections performed.

(1) Nursery inspection fees for all plants, except grass sod, shall be as follows: for less than one-half (1/2) acre of salable stock, *[twenty]* **fifty** dollars *[($20)]* **($50)**; one-half to one (1/2–1) acre of salable stock, *[thirty-five]* **seventy-five** dollars *[($35)]* **($75)**; each additional acre or fraction of an acre, *[three]* **five** dollars *[($3)]* **($5)**. *[Where semi-annual inspections are required, that is, strawberries, brambles, and the like, an annual fee shall be paid at the time of the spring inspection and shall include both inspections performed during the year.]* Grass sod inspection fees shall be as follows: for less than one-half (1/2) acre of salable stock, *[twenty]* **fifty** dollars *[($20)]* **($50)**; one-half to one (1/2–1) acre of salable stock, *[thirty-five]* **seventy** dollars *[($35)]* **($70)**; each additional acre or fraction of an acre, *[one dollar ($1)]* **two dollars ($2)**. **Fees will be paid at the time of initial application and upon annual renewal.**

(2) Fees for the field inspection of grain and forage crops or any other plants or plant products other than nursery stock and sod shall be as follows: for less than one-half (1/2) acre of salable stock, *[twenty]* **fifty** dollars *[($20)]* **($50)**; one-half to one (1/2–1) acre of salable stock, *[thirty-five]* **seventy** dollars *[($35)]* **($70)**; each additional acre or fraction of an acre, *[two]* **four** dollars *[($2)]* **($4)**.

(3) Fees for supervising the fumigation of any plants, plant products, machinery, equipment or any other articles of any nature shall be *[fifty-dollars]* **one hundred dollars** *[($50)]* **($100)** for the first hour worked while on the premises with a *[fifty-dollar]* **one hundred dollar** *[($50)]* **($100)** minimum fee and *[twenty]* **forty** dollars *[($20)]* **($40)** for each additional hour or fraction of an hour worked while on the premises.

(4) Fees for the inspection of grain elevators, warehouses**,** and other facilities shall be *[fifty]* **one hundred** dollars *[($50)]* **($100)** for the first hour worked while on the premises with a *[fifty-dollar]* **one hundred dollar** *[($50)]* **($100)** minimum fee and *[twenty]* **forty** dollars *[($20)]* **($40)** for each additional hour or fraction of an hour while on the premises. These inspections shall be made as often as required by the destination state or country or the United States Department of Agriculture for the issuance of their certificates.

(5) Fees for specialty-type inspections including, but not limited to, phytosanitary, European corn borer, (that is not a grain elevator), vegetable transplant, house plant inspections**,** and any other plant regulatory work shall be *[twenty-five]* **fifty** dollars *[($25)]* **($50)** for the first hour worked while on the premises with a *[twenty-five]* **fifty** dollar *[($25)]* **($50)** minimum fee and *[twenty]* **forty** dollars *[($20)]* **($40)** for each additional hour or fraction of an hour worked while on the premises. There shall be a *[ten-dollar]* **fifty dollar** *[($10)]* **($50)** certification fee for each certificate issued.

(6) Fees for the reissuance of a phytosanitary certificate**,** or any other type of certificate, based upon a prior inspection or some other documentation shall be *[ten]* **fifty** dollars *[($10)]* **($50)**. *[Firms operating under compliance agreements and utilizing state certificates shall pay a certificate fee of five dollars ($5) per certificate.]*

(7) Anyone desiring a phytosanitary inspection and certification or any other type inspection/certification for plants or plant products may bring those plants or plant products to the inspector at a designated time and place at the inspector's choosing and have that inspection performed and a certificate issued, providing the plant material meets the requirements of the destination state or country, for a fee of *[five]* **twenty-five** dollars *[($5)]* **($25)** for the inspection and *[ten]* **fifty** dollars *[($10)]* **($50)** for each certificate issued.

(8) *[Certificates of inspection shall be issued after the inspection is completed and payment of the fee has been received unless otherwise required under sections 263.010–263.080, RSMo or the commodity or plant product being inspected is infested or infected with harmful plant pests or does not meet the requirements of the destination state or country, or both.]* **Payment of inspection and certification fees may be made at the time of inspection, or upon receipt of an invoice from the department. Certificates will not be issued until application has been made, certification requirements have been verified, and previous inspection and certification fees have been paid.** Failure to qualify for certification does not remove the obligation of **the** owner to pay the designated inspection fees.

(9) Fees for greenhouse inspection shall be as follows: for twenty-five thousand (25,000) square feet or less*, [twenty-five]* **fifty** dollars *[($25)]* **($50)**; for twenty-five thousand one to fifty thousand (25,001–50,000) square feet, *[thirty-five]* **seventy** dollars *[($35)]* **($70)**; for each additional twenty-five thousand (25,000) square feet or portion, *[ten]* **twenty** dollars *[($10)]* **($20)**. Fees shall be paid at the time of the fall inspection *[and shall include]* **or upon receipt of an invoice from the department for** both inspections performed during the year.

(10) Nursery dealer registration-inspection certificates shall be *[fifty]* **one hundred twenty-five** dollars *[($50)]* **($125)** annually per outlet and this fee is payable at the time of making application. Restricted nursery dealer registration-inspection certificates shall be *[twenty-five]* **fifty** dollars *[($25)]* **($50)** annually per outlet and this fee is payable at the time of making application. **Nonprofit nursery dealer registration-inspection certificates shall be one hundred twenty-five dollars ($125) annually per nonprofit organization overseeing membership entities and this fee is payable at the time of making application.** If the nursery dealer registration-inspection certificate is not renewed prior to offering nursery stock for sale, there shall be a penalty of fifty percent (50%) assessed and added to the original fee and paid by the applicant before the registration-inspection certificate shall be issued. This penalty is to recover the costs associated with reinspections.

(11) Annual fees for fruit tree and grapevine virus-free certification shall be as follows: three dollars ($3) per registered fruit tree and one dollar ($1) per registered grapevine. Fees are payable by June 30 for the following year's certification.

*[(11)]***(12)** Fees are not prorated and certificates are effective from the time of issuance until the expiration date as mandated by section 263.070, RSMo or the destination state or country.

AUTHORITY: section 263.040, RSMo 2016. Original rule filed Sept. 12, 1984, effective Jan. 1, 1985. Amended: Filed Dec. 2, 1991, effective April 9, 1992. Amended: Filed Oct. 22, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies

or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities two hundred sixty-four thousand four hundred fourteen dollars ($264,414) annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, ATTN: John Brunnert, PO Box 630, 1616 Missouri Boulevard, Jefferson City, MO 65102, or online at Agriculture.Mo.Gov/proposed-rules/. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. **Department Title:** 2 - Agriculture
Division Title: 70 – Plant Industries
Chapter Title: 10 – Missouri Plant Law Rules

Rule Number and Title:	2 CSR 70-10.075 Fee Schedule
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
2100	Nursery Dealers	128,330
550	Nursery Growers	21,012
75	Greenhouse/Exporter/Other	93,072
2	Virus-free Certifications	22,000

III. WORKSHEET

IV. ASSUMPTIONS

Title 2—DEPARTMENT OF AGRICULTURE
Division 70—Plant Industries
Chapter 35—Seed Regulation

PROPOSED AMENDMENT

2 CSR 70-35.050 Submitting Service Samples. The director is amending section (2).

PURPOSE: This amendment updates costs on seed samples.

(2) Charges for analysis and analytical reports on seed samples not qualifying for free analysis as described in section (1) of this rule will be assessed at the following rates:

(A) A cost of *[ten]* **twenty** dollars ($*[10]***20**) per hour will be assessed for purity analysis on any seed having less than ninety percent (90%) pure seed;

(B) Purity analysis on seed having greater than ninety percent (90%) of the crop seed to be planted (purity analysis includes percentage measurements on pure seed, other crop, total weed seed**,** and inert matter) shall be—

1. For one (1) cultivar	$*[12]***24**;
and	
2. For more than one (1) cultivar in the same sample	$*[18]***36**;
(C) Germination (per cultivar)	$*[12]***24**;
(D) Tetrazolium	$*[25]***50**;
(E) Highly chaffy seed purity (per hour)	$*[10]***20**;
(F) Highly chaffy seed germination	$*[14]***28**;
(G) Endophyte from growth	$*[30]***60**;
(H) Endophyte from seed staining	$*[20]***40**;
and	
(I) Noxious and prohibitive weed seed	$*[12]***24**.

AUTHORITY: section 266.091, RSMo 2016. Original rule filed June 6, 1952, effective June 16, 1952. Amended: Filed Dec. 23, 1975, effective Jan. 2, 1976. Amended: Filed June 14, 1977, effective Sept. 11, 1977. Rescinded and readopted: Filed Sept. 28, 1979, effective March 13, 1980. Amended: Filed June 28, 1991, effective Jan. 1, 1992. Amended: Filed Oct. 22, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities one thousand forty-two dollars ($1,042) per year in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, ATTN: John Brunnert, PO Box 630, 1616 Missouri Boulevard, Jefferson City, MO 65102, or online at Agriculture.Mo.Gov/proposed-rules/. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: 2 - Agriculture
Division Title: 70 – Plant Industries
Chapter Title: 35 – Seed Regulations

Rule Number and Title:	2 CSR 70-35.050 Submitting Service Samples
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
18	**Seed buyers, sellers, producers**	**$1,042 annually**

III. WORKSHEET

IV. ASSUMPTIONS

FY18 and FY19 averaged 18 entities submitting seed service sample fees at an annual average aggregate cost of $1,042. Since the seed service sample fees are doubling under this proposed amendment, the estimated aggregate cost of compliance with the rulemaking is $1,042.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 400—Office of Educator Quality

PROPOSED RESCISSION

5 CSR 20-400.150 Application for Certificate of License to Teach. This rule outlined the procedures for application for a certificate of license to teach where the applicant had a recommendation from a state-approved teacher preparation program or had earned a doctoral degree.

PURPOSE: This rule is being rescinded because these requirements are contained within 5 CSR 20-400.500.

AUTHORITY: sections 168.011, 168.405, and 168.409, RSMo 2000, and sections 161.092, 168.021, 168.071, 168.081, and 168.400, RSMo Supp. 2011. This rule previously filed as 5 CSR 80-800.200. Original rule filed April 26, 2000, effective Nov. 30, 2000. For intervening history, please consult the ***Code of State Regulations****. Rescinded: Filed Oct. 25, 2019.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Elementary and Secondary Education, ATTN: Dr. Paul Katnik, Assistant Commissioner, Office of Educator Quality, PO Box 480, Jefferson City, MO 65102-0480 or by email to educatorquality@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 2—Boiler and Pressure Vessel Safety Rules

PROPOSED AMENDMENT

11 CSR 40-2.015 Code/Standards Adopted by Board. The board is amending sections (1)–(11) and adding section (12).

PURPOSE: The division is amending the rule to update the codes and standards adopted by the board to the most current published standards in order to allow those companies installing equipment to avoid unnecessary costs associated with meeting an older code or applying for a variance.

(1) *ASME Boiler and Pressure Vessel Code of the American Society of Mechanical Engineers[,]* **is hereby incorporated by reference in this rule.** *ASME Boiler and Pressure Vessel Code* is published by the American Society of Mechanical Engineers. A copy of this code can be obtained from The American Society of Mechanical Engineers, Three Park Ave, New York, NY 10015-5990 or Internet: www.asme.org, Phone: 1 (800) 843-2763. This regulation does not include any later amendments or additions to the *ASME Boiler and Pressure Vessel Code*:

(A) *[2007]* **2019** ASME Boiler and Pressure Vessel Code; **and**

[(B) 2008 Addendum;]

*[(C)]***(B)** Sections III and XI are exempt from state regulation.

(2) *National Board Inspection Code* (ANSI/nb23)*[,]* **is hereby incorporated by reference in this rule.** The *National Board Inspection Code* is published by The National Board. A copy of this code may be obtained from The National Board, 1055 Crupper Ave, Columbus, OH 43229-1183 or Internet: www.nationalboard.org, Phone: (614) 888-8320. This regulation does not include any later amendments or additions to the *National Board Inspection Code*. NB-23—*Manual for Boiler and Pressure Vessel Inspectors*:

(A) *[2007]* **2019** Edition; Parts 1, 2, and 3, with Part 2 being permissive*[; and]***.**

[(B) 2008 Addendum.]

(3) ASME Code for Power Piping, B31.1 of the American Society of Mechanical Engineers. *ASME Boiler and Pressure Vessel Code* **is hereby incorporated by reference in this rule. It** is published by the American Society of Mechanical Engineers. A copy of this code can be obtained from The American Society of Mechanical Engineers, Three Park Ave, New York, NY 10015-5990 or Internet: www.asme.org, Phone: 1 (800) 843-2763. This regulation does not include any later amendments or additions to the *ASME Boiler and Pressure Vessel Code*.

(A) *[2007]* **2018** Edition.

[(B) 2008 Addendum.]

*[(C)]***(B)** Adopted for Boiler Proper and Boiler External Piping only; requirements for Non-Boiler External Piping and Joint (NBEP) as defined in B31.1, *[2007]* **2018** Edition are permissive.

(4) *Code for Controls and Safety Devices for Automatically Fired Boilers* CSD-1-*[2009]* **2018** Edition of the American Society of Mechanical Engineers. The *Code for Controls and Safety Devices for Automatically Fired Boilers* CSD-1-*[2009]* **2018** edition **is hereby incorporated by reference in this rule. It** is published by the American Society of Mechanical Engineers. A copy of this code may be obtained from The American Society of Mechanical Engineers, Three Park Ave, New York, NY 10015-5990 or Internet: www.asme.org, Phone: 1 (800) 843-2763. This regulation does not include any later amendments or additions to the *Code for Controls and Safety Devices for Automatically Fired Boilers* CSD-1-*[-2009]* **2018**.

(A) With part CM being permissive.

(5) NFPA 85, *Boiler and Combustion Systems Hazards Code*, *[2007]* **2019** Edition. The *Boiler and Combustion Systems Hazards Code* NFPA 85, *[2007]* **2019** Edition **is hereby incorporated by reference in this rule. It** is published by the National Fire Protection Agency. A copy of this code may be obtained from National Fire Protection Agency, 1 Battery Park, Quincy, MA 02169-7471, Internet: www.nfpa.org, Phone: 1 (617) 770-3000. This regulation does not include any later amendments or additions to the *Boiler and Combustion Systems Hazards Code* NFPA 85, *[2007]* **2019** Edition.

(6) NFPA 54, *National Fuel Gas Code* (ANSI Z221.1-2006), *[2009]* **2018** Edition. The *National Fuel Gas Code* NFPA 54, *[2009]* **2015** Edition **is hereby incorporated by reference in this rule. It** is published by the National Fire Protection Agency. A copy of this code may be obtained from National Fire Protection Agency, 1 Battery Park, Quincy, MA 02169-7471, Internet: www.nfpa.org, Phone: 1 (617) 770-3000. This regulation does not include any later amendments or additions to the *National Fuel Gas Code* NFPA 54, *[2009]* **2018** Edition.

(7) *Pressure Vessel Inspection Code, API-510 of the American Petroleum Institute*, *[1997]* **2014** Edition **is hereby incorporated by reference in this rule**. The *American Petroleum Institute 510* is published by the American Petroleum Institute. A copy of this code may be obtained from The American Petroleum Institute, 1220 L Street NW, Washington, DC 20005-4070, Internet: http://api-ec.api.org/frontpage.cfm, Phone: (202) 682-8000. This regulation

does not include any later amendments or additions to the *American Petroleum Institute 510*.

(8) *American National Standard/CSA Standard For Gas-Fired Pool Heaters* (ANSI Z21.56-2006/CSA 4.7-*[2006]* **2013**) **is hereby incorporated by reference in this rule**. A copy of this standard may be obtained from CSA America, 8501 East Pleasant Valley Road, Cleveland, OH 44131-5575, Internet: www.csa-america.org, Phone: (216) 524-4990. This regulation does not include any later amendments or additions to the *Standard for Gas-Fired Pool Heaters*, *[2006]* **2013** Edition.

(9) American National Standard/CSA *Standard for Gas Water Heaters* (ANSI Z21.10.3-20042015/CSA 4.3-*[2004]* **2015**) **is hereby incorporated by reference in this rule**. A copy of this standard may be obtained from CSA America, 8501 East Pleasant Valley Road, Cleveland, OH 44131-5575, Internet: www.csa-america.org, Phone: (216) 524-4990. This regulation does not include any later amendments or additions to the *Standard for Gas Water Heaters*, *[2004]* **2015** Edition.

(10) NFPA 31-*Standard for Installation of Oil-Burning Equipment*, *[2006]* **2016** Edition **is hereby incorporated by reference in this rule**. The Standard for Installation of Oil-Burning Equipment is published by the National Fire Protection Agency. A copy of this code may be obtained from National Fire Protection Agency, 1 Battery Park, Quincy, MA 02169-7471, Internet: www.nfpa.org, Phone: (617) 770-3000. This regulation does not include any later amendments or additions to *[T]*the *Standard for Installation of Oil-Burning Equipment*, *[2006]* **2016** Edition.

(11) ASME PVHO-1-*[2007]* **2016**, *Safety Standard for Pressure Vessels for Human Occupancy* **is hereby incorporated by reference in this rule**. A copy of this code can be obtained from The American Society of Mechanical Engineers, Three Park Ave, New York, NY 10015-5990 or Internet: www.asme.org, Phone: 1 (800) 843-2763. This regulation does not include any later amendments or additions to the ASME S*afety Standard for Pressure Vessels for Human Occupancy*, *[2007]* **2012** Edition.

(12) NFPA 57—*Liquefied Natural Gas (LNG) Vehicular Fuel Systems Code*, 2002 Edition is hereby incorporated by reference in this rule. The *Liquefied Natural Gas Vehicular Fuel Systems Code* is published by the National Fire Protection Agency. A copy of this standard may be obtained from NFPA, 1 Batterymarch Park, Quincy, Massachusetts 02169. This regulation does not include any later amendments or additions to The *Liquefied Natural Gas (LNG) Vehicular Fuel Systems Code*, 2002 Edition.

*AUTHORITY: section 650.215, RSMo [2000] **2016**. Original rule filed Sept. 25, 2002, effective May 30, 2003. Amended: Filed Jan. 12, 2006, effective June 30, 2006. Amended: Filed June 30, 2009, effective Feb. 28, 2010. Amended Filed Sept. 2013. Amended: Filed Oct. 16, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in **Missouri Register**. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

PROPOSED AMENDMENT

11 CSR 40-5.050 New Installations. The division is amending the rule to update the codes and standards adopted by the board to more current published standards in order to allow those companies installing, inspecting and servicing equipment to avoid unnecessary costs associated with meeting an older code or applying for a variance. The Elevator Safety Board is amending sections (1)-(3).

PURPOSE: This amendment adopts standards for new installations.

(1) Minimum Standards. All new elevator equipment shall be constructed and installed in conformity with the standards prescribed in the American Society of Mechanical Engineers, ASME A17.1, *[2004 edition ASME A17.1a Addenda and ASME A17.1s 2005 supplement with amendments]* **2016 edition** adopted by the board, *Safety Code for Elevators and Escalators,* A18.1, *[2005]* **2016** edition, *Safety Standards for Platform Lifts and Stairway Chair Lifts,* ASME A17.2 *[2004]* **2014** edition Guide for Inspection of Elevators, Escalators, and Moving Walks, *American National Standard Institute Safety Code for Manlifts* ANSI A90.1, *[2003]* **2015** edition, *American National Standard Institute Safety Code for Personnel Hoist* ANSI A10.4, *[2004]* **2016** edition, **ANSI/SIA A92.*10 Transport Platforms, 2009, edition*** unless *[as]* exempted by section 701.359, RSMo.

(2) Installation Permit.

(B) Elevator Installation Permit Obtained from the Department.

1. Application for an elevator equipment permit shall be made on a form furnished by the department and shall be submitted by the installing contractor*[, or in the absence of an installing contractor, the owner, operator, lessee or agent of either]*. The application shall require the submission of detailed plans and specifications.

2. Upon receipt of an application for installation of elevator equipment, the required plans and specifications, and the required fee for an elevator equipment permit, the department shall review the application for compliance with the provisions of these rules and regulations. The department shall issue an elevator equipment permit or shall notify the applicant, in writing, of the reasons the elevator equipment permit is denied.

3. Any applicant who has been denied an elevator equipment permit by the department may appeal that denial to the Elevator Safety Board, as provided in 11 CSR 40-50.140 as listed herein.

(C) Elevator installation permit obtained from authorized representative. Procedures for new installation permits shall be defined by the authorized representative.

(3) Inspection and Testing.

(A) Prior to the operation of any new elevator equipment or the issuance of the operating certificate, such elevator equipment shall be inspected by a licensed inspector. Testing must be performed **by a Licensed Mechanic** in accordance with these rules and regulations. The testing must be witnessed by a licensed inspector.

(B) An inspection report shall be filed with the department or its authorized representative, installing contractor and the owner, operator, lessee**,** or agent of either, by the licensed inspector making the inspection within ten (10) days after completion of the inspection. The inspection report shall be on a form furnished and approved by the department or its authorized representative. It shall indicate whether the elevator equipment was installed in accordance with the plans and specifications approved by the department or its authorized representative and meets the requirements of these rules and regulations.

*AUTHORITY: section 701.355, RSMo [2000] **2016**. Original rule filed Aug. 26, 1998, effective July 1, 1999. Amended: Filed Aug. 17, 2000, effective Feb. 28, 2001. Amended: Filed Dec. 16, 2002, effective June 30, 2003. Amended: Filed Dec. 4, 2006, effective May 30, 2007. Amended: Filed Oct. 16, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in **Missouri Register**. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

PROPOSED AMENDMENT

11 CSR 40-5.055 Code Additions, Amendments and Interpretations. The Elevator Safety Board is deleting section (2) and adding a new section (2).

PURPOSE: This amendment eliminates the twelve (12) month effective date mandate originally contained in the rule. This mandate is no longer necessary or applicable due to the fact new elevator equipment is manufactured to the newest code version. The amendment also specifies board approved code deletions and additions within the code referenced.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) The definitions, rules**,** and regulations for new construction shall be based upon and, at all times, follow the generally accepted nationwide engineering standards, formulae**,** and practices established and pertaining to elevator equipment construction and safety, known as the *["]*Elevator and Escalator Safety Code of the American Society of Mechanical Engineers*,[" with all amendments and interpretations thereto made and approved by the council of the society]* **2016 Edition**, which is incorporated by reference in this rule **as published by ASME, Two Park Avenue, New York, NY 10016-5990**. *[Any amendments and interpretations subsequently made and published by the same authority when so adopted shall be deemed incorporated into, and constitute a part of the whole of the definitions, rules and regulations of the board.]* **This rule does not include any later amendments or additions.** Amendments and interpretations to the code shall be effective immediately upon being promulgated, to the end that the definitions, rules**,** and regulations shall at all times follow the generally accepted nationwide engineering standards.

[(2) The rules and regulations and any subsequent amendments thereto, pertaining to the construction of new elevator equipment shall not be mandatory until twelve (12) months after the effective date of the rules and regulations.]

(2) Amendments to American Society of Mechanical Engineers, ASME A17.1, 2016 edition.

(A) Code deletions.

1. Section 1.2.1 Purpose.

2. Section 2.20.1 Suspension Means.

3. Section 2.20.4.2 Aramid Fiber Ropes.

(B) Code additions.

1. Purpose of this code is to provide for safety and to promote the public welfare. The provisions of this code are not intended to prevent the use of systems, methods, or devices of equivalent or superior quality, strength, fire resistance, effectiveness, durability, and safety to those prescribed by this code, provided there is technical documentation to demonstrate the equivalency of the system, method, or device. The specific stipulations of this code may be modified by the authority having jurisdiction based upon technical documentation or physical performance verification to allow alternative arrangements that will assure safety equivalent to that which would be provided by conformance to the corresponding requirements of this code or functions that do not conform with certain requirements in ASME A17.1/CSA B44, but do conform with the applicable requirements in ASME A17.1/CSA B44.7 may be considered by the board for meeting the requirements of this code. Exceptions may be based on the stipulations of the above section.

2. Suspension means.

A. Elevator cars and counterweights shall be suspended by steel wire ropes or noncircular elastomeric-coated steel suspension members attached to the car frame or passing around sheaves attached to the car frame specified in 2.15.1.

B. Suspension means which have previously been installed and/or used on another installation are not to be reused. All suspension members in a set of suspension means need to be the same material, grade, construction, and dimensions. A suitable means is to be provided to protect the suspension means during the installation process. Only the following may be permitted:

(I) Steel wire ropes constructed in accordance with ASME A17.6 2010 Edition, Part 1; or

(II) Noncircular elastomeric-coated steel suspension members constructed in accordance with ASME A17.6 2010 Edition, Part 3.

*AUTHORITY: section 701.355, RSMo [1994] **2016**. Original rule filed Aug. 26, 1998, effective July 1, 1999. Amended: Filed Oct. 16, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COSTS: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

PROPOSED AMENDMENT

11 CSR 40-5.065 Missouri Minimum Safety Codes for Existing Elevator Equipment. The Elevator Safety Board is amending section (1).

PURPOSE: This amendment provides clarity and consistency to sections of the existing rules referencing the proposed updated code adoption in 11 CSR 40-5.050.

(1) In a political subdivision or municipality that had adopted an edition of ASME A17.1 code, *[annual safety inspection and tests]* **elevator equipment** shall *[be performed]* **conform** to the code **requirements** adopted and enforced at the time the elevator equipment was installed. The following standards apply to all existing elevator equipment installed prior to July 1, 1999 as provided in 11 CSR 40-5.060. Any installation which is in compliance with the latest ASME A17.1 version adopted and amended by the Elevator Safety Board, unless as exempted by 701.359, RSMo shall be considered to be in compliance with 11 CSR 40-5.065.

(A) Hoistways.

1. Each passenger elevator hoistway landing shall be protected with a door or gate. The door or gate shall be of solid construction and shall guard the entire entrance.

2. All automatic passenger elevators with power doors shall have non-vision panels on hoistway doors.

3. Each hoistway landing in any elevator hoistway shall be continuously provided with a properly working door or gate.

4. Where freight elevator hoistway doors or gates are of open or lattice construction they shall be at least six feet (6') high and shall come within two inches (2") of the floor when closed. Gates shall be constructed as to reject a ball two inches (2") in diameter. They shall withstand a force of two hundred fifty (250) pounds pressure applied in the center of the gate without breaking or forcing it out of its guides.

5. Manually operated bi-parting entrances of elevators which can be operated from the landings shall be provided with pull straps on the inside and outside of the upper panel where the lower edge of the upper panel is more than six feet six inches (6'6") above the landing when the panel is in the fully opened position.

6. Each hoistway door or gate shall be provided with interlocks designed to prevent the car from moving unless the doors or gates are closed. Where doors or gates do not lock when closed they shall lock when the elevator is not more than twelve inches (12") away from the floor. Passenger elevator hoistway doors shall be closed and locked before the car leaves the floor.

7. All hoistway-door interlocks shall be of the hoistway unit type.

8. Automatic fire doors shall not lock any landing opening in the hoistway enclosure from the hoistway side nor lock any exit leading from any hoistway landing to the outside of the building.

9. Emergency keys for hoistway doors and service keys shall be kept readily accessible to authorized persons.

10. Access means shall be provided at one **(1)** upper landing to permit access to the top of the car, and at the lowest landing if this landing is the normal point of access to the pit.

11. Each hoistway door or gate, which is counterweighted, shall have its weights enclosed in a box-type guide or run in metal guides. The bottom of the guides or boxes shall be so constructed as to retain the counterweight if the counterweight suspension means breaks.

12. Hoistways containing freight elevators shall be fully enclosed. Enclosures shall be unperforated to a height of six feet (6') above each floor or landing and above the treads of adjacent stairways. Unperforated enclosures shall be so supported and braced as to deflect not over one inch (1") when subjected to a force of one hundred (100) pounds applied horizontally to any point. Open work enclosure may be used above the six-foot (6') level and shall reject a ball two inches (2") in diameter.

13. Hoistways containing passenger elevators shall be fully enclosed and the enclosure shall be of solid construction to its full height.

14. Except where vertical opening bi-parting doors are provided, all elevators provided with automatic leveling, inching**,** or teasing devices and where the landing sills project within the hoistway, shall be equipped with a bevel on the underside of the landing sill. Bevels shall be constructed of smooth concrete or not less than sixteen (16) gauge metal securely fastened to the hoistway entrance. Bevels shall extend the full depth of the leveling zone plus three inches (3").

15. Every hoistway window opening seven (7) stories or less on an outside wall above a thoroughfare and every such window three (3) stories or less above a roof of the building or of an adjacent building shall be guarded to prevent entrance by fire or emergency rescue persons. Each such window shall be marked "hoistway" in a readily visible manner.

16. All electrical wiring in the hoistway shall be enclosed in metal conduit, flexible conduit or metal raceway or be in compliance with NFPA 70, *National Electric Code*.

17. No pipes conveying liquids, gases**,** or vapors shall be located in a hoistway. Exception: branch lines for sprinkler system and low pressure steam lines for heating.

(B) Car Enclosure: Passenger.

1. Each passenger car shall be fully enclosed except on the sides used for entrance and exit. The enclosure shall be of solid construction. Grill work at the top of the sides shall not be more than eight inches (8") high. If the car is provided with a solid door and there is no grill work in the enclosure, adequate means of ventilation shall be provided.

2. Each passenger car enclosure shall have a top constructed of solid material. The top shall be capable of sustaining a load of three hundred (300) pounds on any area of two feet (2') on a side and one hundred (100) pounds applied at any point. Simultaneous application of these loads is not required.

3. Passenger car enclosure tops shall have an emergency exit with cover. Opening size shall be as set forth in ASME A17.1, rule 204.1E, 1955 edition. Exception: Hydraulic elevators provided with a manual lowering valve.

4. Each passenger car shall have a door or gate at each entrance. Doors or gates shall be of the horizontally sliding type. Doors shall be of solid construction. Gates shall be of the collapsible type. Gates and doors shall conform to ASME A17.1, rule 204.4, 1955 edition.

5. Each passenger car door or gate shall have an electric contact to prevent the car from running with doors or gates open. Exceptions:

A. By a car-leveling or truck-zoning device;

B. By a combination hoistway access switch and operating device; or

C. When a hoistway access switch is operated.

6. All automatic passenger elevators with power doors shall have reopening devices on the doors, designed to reopen doors in the event the doors should become obstructed.

7. Where a car door or gate of an automatic or continuous-pressure operation passenger elevator is closed by power, or is of the automatically released self-closing type, and faces a manually operated or self-closing hoistway door, the closing of the car door or gate shall not be initiated unless the hoistway door is in the closed position; and the closing mechanism shall be so designed necessary to prevent closing of a horizontally sliding car door or gate from rest

shall be not more than thirty (30) pounds. Exception: Where a car door or gate is closed by power through continuous pressure of a door-closing switch, or of the car operating device, and where the release of the closing switch or operating device will cause the car door or gate to stop or to stop and reopen.

8. Each passenger car shall have lighting inside the enclosure of not less than five (5) foot-candles. Bulbs and tubes shall be guarded to prevent breakage.

9. Each passenger elevator shall have a capacity plate prominently displayed in its enclosure. The capacity plate shall list its capacity in pounds.

10. All passenger elevator car floors shall be maintained so that persons are not exposed to the hazards of tripping or falling.

11. All automatic passenger elevators shall be provided with an alarm bell capable of being activated from inside the car and audible outside the hoistway. If the elevator is not equipped with a bell, a two- (2-)*[-]* way conversation device to the elevator and a ready accessible point outside the hoistway may be acceptable.

12. All automatic passenger elevators shall have their door open zones adjusted to where the door shall not open unless the car has stopped within six inches (6") of floor level.

(C) Car Enclosure: Freight.

1. Each freight elevator car shall have a solid enclosure of at least six feet (6') in height. The space between the solid section and the car top shall be covered solid or with perforated or lattice-type work. The perforated or lattice work shall reject a ball one and one-half inches (1 1/2") in diameter. The portion of open-type enclosure, which passes the counterweights, shall be of solid construction the entire width of the counterweights plus six inches (6") on either side. The enclosure top shall be provided with an emergency exit. Exception: Hydraulic elevators provided with a manual-lowering valve.

2. Each freight car enclosure shall have doors or gates at each entrance and shall be not less than six feet (6') high. Each door or gate shall be constructed in accordance with ASME A17.1, rule 204.4, 1955 edition.

3. Each car door or gate on a freight elevator shall have electric contacts to prevent the car from running with doors or gates open. Exceptions:

A. By a car-leveling or truck-zoning device;

B. By a combination hoistway access switch and operating device; or

C. When a hoistway access switch is operated.

4. Each freight elevator car enclosure shall be provided with a top. The top may be solid or open-work construction and shall be of metal. The open work shall reject a ball two inches (2") in diameter. Car tops shall be constructed to sustain a load of two hundred (200) pounds applied at any point on the car top. The top shall not have hinged or folding panels other than the emergency exit cover.

5. Each freight car enclosure shall have lighting not less than two and one-half (2 1/2) foot-candles. Bulbs or tubes shall be guarded to prevent breakage.

6. Each freight car enclosure shall have capacity plate, loading class plates, and a "No Passengers" sign conspicuously posted. Letters shall not be less than one-half inch (1/2") high.

7. Freight elevators shall not be loaded to exceed the rated load as stated on their capacity plates.

8. Each freight elevator car floor shall be maintained so that personnel will not readily slip or trip. The floor shall be maintained so that it will hold its rated load without breaking through at any place in the car.

9. Freight elevators shall not be permitted to carry passengers other than persons to load and unload material and the operator. Permission may be granted to allow the carrying of employees on freight elevators. Application shall be submitted and may be approved by the authorized representative after which the installation shall be tested as determined by the Department of Public Safety.

(G) Maintenance, Repair and Alterations.

1. All maintenance, repair and replacement shall comply with **the applicable standard established by 11 CSR 40-5.050(1)** ASME A17.1, section 8.6 *[2004 edition with 2005 Addenda and 2005 supplement] **Safety Code for Elevators and Escalators***.

2. All alterations shall comply with **the applicable standards established by 11 CSR 40-5.050(1)** ASME A17.1, section 8.7 *[2004 edition with ASME A17.1a 2005 Addenda and ASME A17.1S 2005 supplement] **Safety Code for Elevators and Escalators***.

3. All maintenance, repair and alterations to platform lifts and stairway chair lifts shall comply with **the applicable standards established by 11 CSR 40-5.050(1)** ASME A18.1, *[2005 edition,] Safety Standard for Platform Lifts and Stairway Chair Lifts*.

(H) Machine Rooms.

1. All means of access to elevator machine rooms shall be of a permanent nature and shall be constructed and maintained in a clear and unobstructed manner.

2. The elevator machine and control equipment shall be located in a separate room or separated space designed as an elevator machine room or space and shall be accessible only to authorized personnel. Existing machines and equipment essential to the operation and purpose of the building are permitted but must not interfere with the safety and work area for maintaining elevator equipment. Pipes conveying liquid, gas, or vapor that cross overhead of elevator equipment or come in close proximity of the equipment shall be guarded or guttered. Where other existing machines and equipment essential to the operation and purpose of the building are located in the machine room or space, the elevator related equipment and machines shall be separated by a substantial grill constructed of non-combustible material not less than six feet (6') high and the grill shall be of a design that will reject a ball two inches (2") in diameter. All rooms or enclosures shall have a self-closing and self-locking door and shall be operable from the interior space without use of a key. After the effective date of this rule, no equipment shall be added to the machine room or space that is not used in connection with the operation of the elevator.

3. All elevator machine rooms shall be provided with a floor. The floor shall cover the entire area of the machine room and hoistway.

4. Machine room floors shall be kept clean and free of grease and oil. Articles or materials not necessary for the maintenance or operation of the elevator shall not be stored therein. Flammable liquids having a flash point of less than one hundred ten degrees Fahrenheit (110°F) shall not be stored in the machine room.

5. Lighting in the machine room shall be not less than ten (10) foot-candles at floor level.

6. Where there is more than one machine in a room, each machine shall have a different number conspicuously marked on it. The controller, disconnect switch and relay panels for each machine shall be conspicuously numbered to correspond to the machine it controls.

7. All electrical equipment in the machine room shall be grounded which shall conform to ASME A17.1, 1996 edition and NFPA, 70, *National Electric Code*.

8. All electrical wiring in the machine room shall be enclosed in metal conduit, flexible conduit or metal raceways or be in compliance with NFPA 70, *National Electric Code*.

9. Each elevator having polyphase alternating current power supply shall be provided with means to prevent the starting of the elevator motor if:

A. The phase rotation is in the wrong direction; or

B. There is a failure of any phase. This protection shall be considered provided in the case generator-field control having alternating current motor-generator driving motors, provided a reversal of phase will not cause the elevator driving-machine motor to operate

in the wrong direction. Controllers whose switches are operated by polyphase torque motors provide inherent protection against phase reversal or failure.

(I) Pits.

1. All pits shall be kept dry, clean**,** and free of equipment or material not relating to the operation of the elevator. Exception: Sump pumps.

2. Buffers (spring or oil type) under cars and counterweights shall be permanently fastened to the floor or their supporting beams.

3. All elevators shall have counterweight guards. Guards shall be of unperforated metal of at least the strength of or braced to the equivalent strength of number fourteen (14) gauge sheet steel. Guards shall extend from a point not more than twelve inches (12") above the pit floor to a point not less than seven feet (7') above the pit floor. Where guards are not feasible, warning chains shall be installed on the bottom of the counterweights and shall extend no less than five feet (5') below counterweight. Chains shall be of a number ten (10) U.S. gauge wire or of equal size. Exception: When compensating chains or ropes are used, a counterweight guard is not required.

4. Buffers shall be installed where elevator pits are not provided with buffers and where the pit depth will permit, buffers shall comply with ASME A17.1, 1955 edition, section 201.

5. Where the depth of any pit is four feet (4') or more it shall have a ladder permanently installed. The ladder shall extend not less than thirty inches (30") above the sill of the access door, or hand grips shall be provided to the same height. Ladder shall be of noncombustible material.

6. A permanent lighting fixture shall be provided in all pits to provide an illumination of not less than five (5) foot-candles at the pit floor. The fixture switch shall be provided and accessible from the pit access door.

7. An enclosed stop switch meeting the requirements of ASME A17.1, 1995 edition, rule 210.2(e) shall be installed in the pit of all power elevators and be accessible from the pit access door.

8. Pit sump holes, with or without pumps, and well holes that are accessible, shall be covered flush with the pit floor. The covering shall consist of a noncombustible material.

(J) Counterweights.

1. Broken or cracked sections of counterweights shall be replaced.

2. Counterweight hanger rods, tie rods or both shall firmly support and secure the counterweight sections in place.

3. Wire ropes extending through counterweights from one **(1)** stack to another shall be guarded by metal sleeves attached to the wire ropes. Guards shall be of a suitable design to prevent accidental crushing or deforming for the ropes and rope sockets. Stacks shall not be spaced less than eight inches (8") apart.

(K) Car Platforms and Car Slings.

1. All platforms shall be soundly constructed without cracks or breaks in stringers or frames. All floors shall be free of holes.

2. All car slings shall be soundly constructed and free of cracks or breaks.

3. Where cable sheaves are used on the crosshead, they shall be firmly attached and free of cracks or breaks.

4. All elevators shall have data plates attached to the crosshead.

5. All elevators with automatic leveling, inching or teasing devices shall have a platform guard or an apron. All other elevators shall have warning chains hung within two inches (2") of the edge of the platform on the entrance sides. Chains shall be of number ten (10) U.S. gauge wire or of equal size. Chains shall extend not less than five feet (5') below the platform and shall not be spaced more than four inches (4") apart.

6. All car slings shall have guide shoes at the top and bottom of the sling. Shoes that are worn to a degree which affect the safe operation of the car shall be repaired or replaced.

(L) Wire Ropes—Hoisting, Governor**,** and Tiller.

1. All hoisting and governor ropes, when replaced, shall have rope tags. The tags shall provide the following information:

A. The diameter in inches;

B. The manufacturer's rated breaking strength;

C. The grade of material used;

D. The month and year ropes were installed;

E. Whether preformed or non-preformed;

F. Construction classification;

G. Name of person or firm who installed ropes; and

H. Name of manufacturer of ropes.

2. Wire ropes on drum-type machines shall be resocketed in compliance with ASME A17.1, 1996 edition, rule 1206.3.

3. Suspension ropes on drum-type machines shall have not less than one (1) turn of the rope on the drum when the car is resting on the fully compressed buffers.

4. Winding drum machines shall not be used unless they are provided with not less than two (2) hoisting ropes. Each counterweight stack shall be provided with not less than two (2) ropes.

5. Tiller cables on cable-operated elevators shall be kept free of breaks.

6. On tiller-cable operations, the cable shall pass through a guiding or stopping device mounted on the car. The cable shall be provided with adjustable stop balls and be provided with means to lock and hold the car at a floor. Stop balls at top and bottom shall be adjusted to automatically stop the car. The tiller cable shall be completely enclosed in the hoistway.

7. All hoisting or counterweight ropes located outside of the hoistway that are exposed shall be covered with a box-type guard. The guard shall be not less than six feet (6') high from floor level.

8. Hoisting, governor and tiller ropes shall not be lengthened or repaired by splicing.

9. Suspension means of chains other than a roller chain type shall not be allowed. Any elevator suspended by a roller chain type shall not be used for the carrying of passengers. Exception: Elevators for the disabled.

10. Hoisting ropes for power elevators shall not be less than three-eighths inch (3/8") in diameter.

11. Hoisting rope fastening means shall be of the socket, babbitting or wedge type. Clamps shall not be used.

12. Rope (cable) replacement. Hoisting, governor and tiller ropes shall be replaced when the Inspection of Elevators, Escalators and Moving Walks, ASME A17.2, 1996 edition Inspectors' Manual, Division 103, Item 103.4 dictates they shall be changed.

(M) Car Safeties and Speed Governors.

1. Each elevator suspended by ropes shall be provided with mechanically applied car safeties which shall be capable of stopping and sustaining its rated load.

2. Broken rope or slack rope safeties may be allowed if the car speed is not in excess of fifty feet per minute (50 fpm).

3. Elevators which are provided solely with broken rope or slack rope safeties shall not be used for passenger service. Exception: Elevators for the disabled.

4. All safeties shall be adjusted so that clearances from the rail shall be in accordance with ASME A17.1, 1955 edition rule 1001.2.

5. All slack cable safeties shall be provided with an electrical switch which disconnects power to the elevator machine and brake when setting of the safeties occurs.

6. All safeties operated by a speed governor shall be provided with a speed switch operated by the governor when used with type B or C car safeties on elevators having a rated speed exceeding one hundred fifty (150) fpm. A switch shall be provided on the speed governor when used with a counterweight safety for any car speed.

7. Speed governors shall have their means of speed adjustment sealed.

8. For hoistways not extending to the lowest floor and where space below the hoistway is used for a passageway or is occupied by persons, or if unoccupied but not secured against unauthorized access, the counterweights of the elevator shall be provided with safeties. Safeties shall be tripped by a speed governor if the car speed

is in excess of one hundred fifty (150) fpm. Speed governors shall be set to trip above the car governor tripping speed but not more than ten percent (10%) greater.

(N) Guide Rails.

1. All guide rails and brackets whether of wood or steel shall be firmly and securely anchored or bolted in place. Where T rail is used all fish-plate bolts shall be tight. This shall comply with ASME A17.1, 1955 edition, section 200.

2. Where guide rails which are worn to such a point that proper clearance of safety jaws cannot be maintained, the worn sections shall be replaced to achieve clearances as specified in ASME A17.1, 1996 edition, rule 1001.2.

(O) Existing Hydraulic Elevators.

1. Cylinders of hydraulic-elevator machines shall be provided with a means for releasing air or other gas.

2. Each pump or group of pumps shall be equipped with a relief valve conforming to the following requirements:

A. Type and location. The relief valve shall be located between the pump and the check valve and shall be of such a type and so installed in the bypass connection that the valve cannot be shut off from the hydraulic system;

B. Setting. The relief valve shall be preset to open at a pressure not greater than that necessary to maintain one hundred twenty-five percent (125%) of working pressure;

C. Size. The size of the relief valve and bypass shall be sufficient to pass the maximum rated capacity of the pump without raising the pressure more than twenty percent (20%) above that at which the valve opens. Two (2) or more relief valves may be used to obtain the required capacity; and

D. Sealing. Relief valves having exposed pressure adjustments if used, shall have their means of adjustment sealed after being set to the correct pressure. Exception: No relief valve is required for centrifugal pumps driven by induction motors, provided the shut-off, or maximum pressure which the pump can develop, is not greater than one hundred and thirty-five percent (135%) of the working pressure at the pump.

3. Storage and discharge tanks shall be covered and suitably vented to the atmosphere.

4. All repair and alterations of hydraulic elevators shall comply with ASME A17.1, 1996 edition, section 1201 with supplements thereto.

(P) Existing Sidewalk Elevators.

1. Hoistways shall be permanently enclosed. The enclosures shall conform to ASME A17.1, 1955 edition rule 401.1.

2. All interior landings shall have a door or gate which shall be provided with an interlock.

3. Doors opening in sidewalks or other areas exterior to the building shall be of the hinged type. Doors or covers shall be designed to hold a static load of three hundred pounds per square foot (300 ppsf). Doors shall always be closed unless elevator is at the landing.

4. Stops shall be provided to prevent the cover in the opening of the sidewalk from opening more than ninety degrees (90°) from its closed position.

5. Covers in sidewalk shall be designed to close when the car descends from the top landing.

6. Recesses or guides which will securely hold the cover in place on the car stanchions shall be provided on the underside of the cover.

7. All electrical wiring shall be enclosed in metal conduit, flexible conduit**,** or metal raceways. If hoistway opens in the sidewalk, the wiring shall be weatherproof.

8. Operating devices and control equipment shall comply with ASME A17.1, 1955 edition, rule 402.4.

9. All electric sidewalk elevators shall have upper and lower final limit switches. Open-type switches shall not be allowed.

10. Cars shall have enclosures which shall be not less than six feet (6') in height provided the stanchions and bow iron are of sufficient height. The enclosure shall be provided with electric contacts to prevent the car from running with doors or gates open.

11. Cars shall have safeties. Where the speed of the elevator does not exceed fifty (50) fpm, car safeties which operate as a result of breaking or slackening of the hoisting ropes may be used. Such safeties may be of the inertia type or approved type without governors. Governors shall not be required when car speed does not exceed fifty (50) fpm.

12. Car enclosures and car gates shall not be required for hand-powered sidewalk elevators.

13. All repair and alterations shall comply with ASME A17.1, 1955 edition, section 1200.

(Q) Existing Hand Elevators.

1. Hand-powered elevators shall have hoistway doors. Doors shall be of the self-closing and self-locking type.

2. Hoistway doors shall have signs attached to them indicating elevator hoistway. Sign shall be as follows in not less than two-inch (2") letters: DANGER ELEVATOR—KEEP CLOSED.

3. All hand-powered elevators shall be provided with safeties or slack cable devices. Safeties do not have to be operated by a speed governor unless the speed is in the excess of fifty (50) fpm.

4. Hand-powered elevators shall have a car enclosure which shall be constructed of metal or sound seasoned wood. The enclosure shall cover all sides which are not used for entrance or exit. The enclosure shall be secured to the car platform or frame in such a manner that it cannot work loose or become displaced in ordinary service.

5. Each hand-powered elevator shall be provided with a brake which shall be capable of stopping and sustaining the car whether loaded or unloaded.

6. Hand-powered elevators shall not be converted or changed to electric powered unless the complete facility is brought into conformity with ASME A17.1, 1996 edition.

7. Repair or replacement of worn or broken parts shall be in compliance with ASME A17.1, 1996 edition, rule 1202.2.

(R) Power Operated Special Purpose Elevators.

1. Elevators complying with the following requirements may be installed in any structure where the elevator is not accessible to the general public, is used exclusively for designated operating and maintenance employees only, and where transportation of one (1) or two (2) persons is required to attend machinery or equipment frequently.

2. The inside platform area of the car shall not exceed nine (9) square feet. The rated speed shall not exceed one hundred (100) fpm. The rated load shall not exceed six hundred fifty (650) pounds.

3. Hoistways shall be enclosed to their full width, to a height of not less than seven feet (7') with solid or perforated noncombustible material braced to deflect not more than one inch (1") when subjected to a force of one hundred (100) pounds applied horizontally at any point. Open work enclosures shall be at least number thirteen (13) steel wire gauge or expanded metal at least number thirteen (13) U.S. gauge and shall reject a ball two inches (2") in diameter. Where counterweights pass, landing and stairway side shall be of solid construction.

4. Wiring shall comply with the requirements of ASME A17.1, 1978 edition and NFPA 70.

5. Counterweights shall comply with the requirements of ASME A17.1, 1978 edition, Part XV.

6. Hoistway doors shall comply with rules ASME A17.1, 1978 edition, Part XV.

7. Cars shall be solidly constructed in accordance with ASME A17.1, 1978 edition, Part XV.

8. Car enclosure.

A. Except at the entrance, the car shall be enclosed on all sides and the top. The enclosure at the sides shall be solid or open work. All open work shall reject a ball one inch (1") in diameter. The enclosure shall be constructed of sufficient strength that it will not deflect more than one inch (1") at any one (1) point.

B. There shall be an electric light to illuminate the car or

hoistway with the switch placed on or near the operating panel.

C. There shall be no glass used in the elevator car except for the car light.

9. A car door shall be provided at each car entrance. Door or gate shall guard the complete entrance. The door or gate shall be at least seven feet (7') high, of metal construction with solid or open construction to reject a ball one inch (1") in diameter. A contact switch shall be provided to prevent the operation of the elevator with doors or gates open. The door or gate shall be provided with interlocks.

10. Guide rails shall comply with ASME A17.1, 1978 edition, Part XV.

11. The means and methods of suspension shall comply with ASME A17.1, 1978 edition, Part XV.

12. Electrical switches shall comply with ASME A17.1, 1978 edition, Part XV.

13. Brakes shall comply with ASME A17.1, 1978 edition Part XV.

14. Emergency signal or communication shall comply with ASME A17.1, 1978 edition, Part XV.

(S) Fire Service.

1. Elevators with fire service features shall comply with the edition of ASME A17.1 that the elevator was constructed to meet.

(T) Existing Dumbwaiters, Escalators**,** and Moving Walks.

1. Dumbwaiters. All dumbwaiters whether electric or hand powered shall conform to ASME A17.1, 1971 edition, section 700. Exceptions: Required rules for hoistway construction as set forth in ASME A17.1, 1971 edition shall not apply to existing installations.

2. Escalators.

A. Each escalator shall be provided with an electrically released mechanically applied brake capable of stopping the up and down traveling escalator with any load up to and including the rated load. The brake shall be located either on the driving machine or on the main drive shaft.

B. Starting switches shall be of the key-operated type. Starting switches shall be located on or near the escalator.

C. Emergency stop buttons or other type manually operated switches having red buttons or handles shall be accessibly located at or near the bottom and top landings. The buttons or levers shall be protected to prevent accidental operation.

D. A broken step-chain device shall be provided on each escalator that will cause interruption of power to the driving machine if a step chain breaks or if excessive sag occurs in either step chain.

E. Each escalator shall have comb plates at top and bottom landings of the escalator. Comb plate teeth shall be meshed with and set into slots in the tread surface of the steps so that the points of the teeth are always below the upper surface of the treads.

F. Each escalator balustrade or molding on the balustrade shall have a smooth surface. Screw heads shall set flush with the surface or be of the oval head type without any burrs or rough places on their surface.

G. The clearance on either side of the steps between the step tread and the adjacent skirt panel shall be not more than three-sixteenths inch (3/16").

H. Step treads shall be illuminated throughout their run. The light intensity shall be not less than two (2) foot-candles.

I. An enclosed fused disconnect switch or circuit breaker arranged to disconnect the power supply to the escalator shall be in each machine room or wherever the controller is located.

J. A stop switch shall be provided in each machinery space where means of access to the space is provided. The switch when opened shall cause electric power to be removed from the escalator driving-machine motor and brake. The switch shall be of the manually opened and closed type and shall be marked "STOP."

K. Hand or finger guards shall be provided at the point where the handrail enters the balustrade.

L. Where the clearance of the upper outside edge of the balustrade and a ceiling or scaffold is less than twelve inches (12") or where the intersection of the outside balustrade and a ceiling or soffit is less than twenty-four inches (24") from the centerline of the handrail, a solid guard shall be provided in the intersection of the angle of the outside balustrade and the ceiling or soffit. The vertical front edge of the guard shall project a minimum of fourteen inches (14") horizontally from the apex of the angle. The escalator side of the vertical face of the guard shall be flush with the face of the wellway. The exposed edge of the guard shall be rounded.

3. Moving walks.

A. Each moving walk shall be provided with an electrically released, mechanically applied brake capable of stopping and holding treadway with a load up to and including the rated load.

B. Starting switches shall be of the key-operated type and shall be located within sight of the exposed treadway.

C. Each moving walk shall be provided with an emergency stop button or manually operated switch at each entrance and exit. The switches shall be protected to prevent the accidental operation of them. The operation of any of these switches shall interrupt the power to the driving-machine motor and brake.

D. A device shall be provided which will cause interruption of power to the driving-machine motor and brake if the connecting means between pallets break.

E. The entrance to and exit from a moving treadway shall be provided with a threshold plate which shall have teeth and be adjusted so that the teeth are below the treadway.

F. An enclosed fused disconnect switch or a circuit breaker arranged to disconnect the power supply to the moving walk shall be provided in the space where the controller is located.

G. If the balustrade covers the edge of the treadway the clearance between the top surface of the treadway and the underside of the balustrade shall not exceed one-fourth inch (1/4"). Where skirt panels are used the horizontal clearance on either side of the treadway and the adjacent skirt panel shall be not more than one-fourth inch (1/4").

H. A stop switch shall be provided in each machinery space where means of access to the space is provided. The switch when opened shall cause electrical power to be removed from the driving-machine motor and brake. The switch shall be of the manually operated type, and shall be marked "STOP."

I. Hand or finger guards shall be provided at the point handrails enter the balustrade.

J. All balustrades shall be smooth and free of rough surfaces. All screws shall be flush or oval head. Screw heads shall be smooth and free of burrs.

K. On pallet type treadways adjacent ends of the pallets shall not vary in elevation more than one-sixteenth inch (1/16"). The distance between pallets shall not exceed five thirty-seconds inch (5/32").

L. All repairs and alterations shall comply with ASME A17.1, 1996 edition.

(U) Existing Vertical and Inclined Platform Lifts.

1. Existing vertical and inclined platform lifts shall meet the requirements of ASME A17.1, 1984 edition, Part 20.

(V) Existing Manlifts.

1. Existing manlifts shall be inspected per the requirements of ASME A90.1, 1997 edition.

*AUTHORITY: section 701.355, RSMo [2000] **2016**. Original rule filed Aug. 26, 1998, effective July 1, 1999. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Oct. 16, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

PROPOSED AMENDMENT

11 CSR 40-5.070 Accessibility to the Disabled. The Elevator Safety Board is amending section (1).

PURPOSE: This amendment changes the rule to adopt the most current version of the standard used to ensure accessibility to elevator equipment meets ADA requirements.

(1) New Installations of Accessible Passenger Elevators and Wheelchair Lifts. In addition to the standards imposed, the board hereby adopts and incorporates herein the *American National Standards Institute Standard for Buildings and Facilities Providing Accessibility and Usability for Physically Disabled People,* ANSI A117.1 *[2003]* **2009** edition, Sections 407, 408, and 410, American Society of Mechanical Engineers (ASME), Three Park Avenue, New York, NY 10016 adopted by the Elevator Safety Board. This rule does not include any later amendments or additions.

*AUTHORITY: section 701.355, RSMo [2000] **2016**. Original rule filed Aug. 26, 1998, effective July 1, 1999. Amended: Filed Dec. 16, 2002, effective June 30, 2003. Amended: Filed Dec.4, 2006, effective May 30, 2007. Amended: Filed Oct. 16, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

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Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

PROPOSED AMENDMENT

11 CSR 40-5.080 Alterations. The Elevator Safety Board is amending sections (1) and (3).

PURPOSE: This amendment ensures consistency in the references to code versions in the elevator safety rules; replaces obsolete terminology and code references with current terminology and code references; and requires testing be performed by a licensed mechanic.

(1) Minimum Standards. When any alterations are made, all elevator equipment, as a minimum, shall conform to the applicable requirements of section 8.7 of the ASME A17.1 *[2004 edition with 17.1 2005 addendum and 2005 supplement]* as amended by the Elevator Safety Board.

(A) **Major** Alterations listed below require an alteration permit to be obtained and submission of plans or scope of work for review by the division. The plan review fee is one hundred fifty dollars ($150) plus twenty-five dollars ($25) per each floor opening including the bottom floor plus twenty-five dollars ($25) for the alteration permit fee. An acceptance inspection shall be conducted after completion of the alteration.

Item	Electric	Hydraulic	MW & Esc.
*[**Alternating current, change to direct current]*			
****Change in Power Supply**	8.7.2.27.3	8.7.3.31.4	
*Car, increase/decrease in dead weight of **Car**	8.7.2.15.2	8.7.3.21	
**Controller	8.7.2.27.4	8.7.3.31.5	
*[**Direct current, change to alternating current*	*8.7.2.27.3*	*8.7.3.31.4]*	
*[**Driving machine]*			
****Alterations to Driving Machines and Sheaves**	8.7.2.25.1		
****Hydraulic Jack**		8.7.3.23.1	
*Driving machine, change in location	8.7.2.25.2	8.7.3.23.6	
Electrically operated control valve **in place of Mechanical valve		8.7.3.24	
*[**Freight elevator change to passenger service]*			
Carrying of Passengers of Freight Elevators	8.7.2.16.3	8.7.3.*[17]***19**	
*Increase in rated load	8.7.2.16.4	8.7.3.20	
*[**Increase in rated speed*	*8.7.2.17.1*	*8.7.3.22.2&3*	
**Increase in travel*	*8.7.2.17.1*	*8.7.3.22.1]*	
***Change in Rise or Rated Speed**	**8.7.2.17**		
***Change in Travel or Rated Speed**		**8.7.3.22**	
*[*Operation, change in type of]* ***Change in Type of Service**	8.7.2.16.1	8.7.3.17	
***Change in Type of Operation Control**	**8.7.2.27.6**	**8.7.3.31.7**	
*[**Pressure, working change in]*			
**** Increase in working pressure**		8.7.3.23.4	
*Addition of elevator to existing hoistway	8.7.2.1.2	*[8.7.2.1.2]*	
***Hoistway Enclosures**		**8.7.3.1**	
*[**Car decrease or increase in dead weight of]*			
****Increase or Decrease in Deadweight of Car.**	8.7.2.15.2	8.7.3.21	
*[*Decrease in travel*	*8.7.2.17.1*	*8.7.3.22.1*	
**Freight elevator permitted to carry passengers*	*8.7.2.16.3*	*8.7.3.19]*	
*[*Location of driving machine, change in]*			
***Change in Location of Driving Machine**	8.7.2.25.2	8.7.3.23.*[4]***6**	
*Location of hydraulic jack, change in		8.7.3.23.5	
*[*Location of hydraulic machine, change in*		*8.7.3.23.6]*	
*Relocation of moving walk			8.7.6.2.2
*Relocation of escalator			8.7.6.2.1
***Trusses and Girders (New onto Existing Truss) Escalator**			**8.7.6.1.9**
***Trusses and Girders (New onto Existing Truss) Moving Walk**			**8.7.6.2.9**
*Top of car operating device	8.7.2.27.1	8.7.3.31.1	
****Change in Suspension Means**	**8.7.2.21.1**	**8.7.3.25.1**	

* Plans submitted with permit
** Scope of work submitted with permit

(B) Alterations **and major repairs** listed below only require an alteration permit to be obtained and an acceptance inspection conducted. Alteration permit fee is twenty-five dollars ($25).

Item	Electric	Hydraulic
*Buffer	8.7.2.23	8.7.3.27
*Car safeties	8.7.2.18	8.7.3.15
*[**Check valve*		*8.7.3.24]*
*[**Control valve]* ****Valves, Pressure Piping, and Fittings**		8.7.3.24
*Counterweight safeties	8.7.2.18	8.7.3.15
*Hydraulic Jack		8.7.3.23
*[**Door, power operation of]*		
****Power Operation of Hoistway Doors**	8.7.2.12	8.7.3.*[10]***12**
**Emergency operation *[(not signaling devices)]*	8.7.2.28	8.7.3.31.8
**Final terminal stopping device	8.7.2.26	(none)
**Firefighters service	8.7.2.28	8.7.3.31.8
*[*Governor*	*8.7.2.19*	*8.7.3.16]*
*[**Governor rope (not if same type, size and material)]*		
****Speed Governor and Governor Ropes.**	8.7.2.19	8.7.*[2.]***3.**16

Item	**Electric**	**Hydraulic**
**Guide rail	8.7.2.24	8.7.3.28
*[**Hoist-way door, power operation of*	*8.7.2.12*	*8.7.3.12]*
**Normal terminal stopping device	8.7.2.26	8.7.3.30
**Piping supply		8.7.3.24
*Piston		8.7.3.23.2
*[**Rope, suspension (not if same type, size & material)*	*8.7.2.21.1*	*8.7.3.25.1]*
**Plunger Gripper		8.7.3.23.7
*Operating device	8.7.2.27	8.7.3.31
*[*Overlay*	*8.7.2.27.6*	*8.7.3.31.5]*
*[**Sleeving]* **Cylinders replaced, altered or sleeved**		8.7.3.23.3
*[*Spring Buffer*	*8.7.2.27*	*8.7.3.27]*
*[**Wire rope]* **Suspension Means and Their Connections**	8.7.2.21	8.7.3.25
*[**Valve*		*8.7.3.24]*
**Brake	8.7.2.25.1**(a)**	
Capacity, Loading and Classification**	8.7.2.16	**8.7.3.18**

* Plans submitted with permit
** Scope submitted with permit

(C) All other alterations are required to conform to **11 CSR 40-5.050 ASME** A17.1*[-2004 with 2005 Addendum and 2005 Supplement]* section 8.7. **as amended by the Elevator Safety Board.**

(2) Alteration Permit.

(B) Alteration Permit Obtained from the Department.

1. Application for an alteration permit shall be made on a form furnished by the department and shall be submitted by the installing contractor*[, or in the absence of an installing contractor, the owner, operator, lessee or agent of either]*. The application shall require the submission of detailed plans and specifications.

2. Upon receipt of an application and the required fee for an alteration permit, the required plans and specifications, shall be reviewed by the department for compliance with the provisions of these rules and regulations. The department shall issue an alteration permit or shall notify the applicant in writing of the reasons the alteration permit is denied.

3. Any applicant who has been denied an alteration permit by the department may appeal that denial to the Elevator Safety Board, as provided in 11 CSR 40-5.140 as listed herein.

(3) Inspection and Testing.

(A) Prior to the operation of any elevator equipment, which has undergone an alteration or major repair and prior to the issuance of a new operating certificate, the elevator equipment shall be inspected by a licensed inspector. Testing must be performed **by a licensed mechanic** in accordance with these rules and regulations. The testing must be witnessed by a licensed inspector.

(B) An inspection report shall be filed with the department or its authorized representative, installing contractor and the owner, operator, lessee**,** or agent of either, by the licensed inspector within ten (10) days after completion of the inspection. The inspection report shall be on a form furnished and approved by the department or its authorized representative. It shall indicate whether the elevator equipment was installed in accordance with the plans and specifications approved by the department or its authorized representative and meets the requirements of these rules and regulations.

*AUTHORITY: section 701.355, RSMo [2000] **2016**. Original rule filed Aug. 26, 1998, effective July 1, 1999. Amended: Filed Dec. 16, 2002, effective June 30, 2003. Amended: Filed Dec. 4, 2006, effective May 30, 2007. Amended: Filed Oct. 16, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

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Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

PROPOSED AMENDMENT

11 CSR 40-5.090 Inspection and Testing. The Elevator Safety Board is amending sections (1)–(3).

PURPOSE: This amendment clarifies terminology within this rule and removes obsolete references to codes.

(1) Minimum Standard. All inspections and testing required by Missouri Statute 701.350–701.380 and these rules and regulations shall be made in accordance with the **applicable** standards established by *[these rules and regulations and the American Society of Mechanical Engineers Manuals for Elevators and Escalators, ASME A17.1 April 30, 2004, with A17-1a April 29, 2005 Addenda and 17.1s March 23, 2005 supplement, 17.2 March 20, 2005, and A18.1 November 29, 2005, American Society of Mechanical Engineers (ASME), Three Park Avenue, New York, NY 10016,]* **11 CSR 40-5.050,** adopted by the Elevator Safety Board excluding periodic inspection requirements of Table N-1, six- (6-)*[-]* month interval in ASME A17.1 The requirements of the six- (6-)*[-]* month periodic inspection is to be performed with the twelve- (12-)*[-]* month periodic inspection. The foregoing standards are incorporated by reference in this rule. This does not include any later amendments or additions.

(2) Periodic Inspections.

(A) The owner, operator, lessee, or agent of either of any elevator equipment as described herein shall have it inspected, every twelve (12) months, as defined by sections 701.350–701.380, RSMo and these rules and regulations. The inspection may be made within thirty (30) days prior to or thirty (30) days following the anniversary date of the initial inspection. Other variations to the twelve- (12-)*[-]* month inspection period may be authorized by the chief elevator inspector as deemed necessary to schedule inspections in remote locations or for multiple elevator equipment situations.

(3) Testing Procedures.

(C) Tests required by these rules and regulations shall be made by a *[person qualified]* **licensed elevator mechanic** to perform such service employed by the owner, operator, lessee**,** or agent of either, in the presence of a licensed inspector. The department has within its discretion, the authority to allow the testing to be performed without a licensed inspector present. In such cases, the elevator equipment shall be properly tagged by the qualified person performing the testing. The inspector shall verify the proper tagging of the elevator equipment within a ten- (10-)*[-]* day period. It will be required, without exception, that the testing be witnessed in the presence of a licensed inspector, at least every five (5) years.

*AUTHORITY: section 701.355, RSMo [2000] **2016**. Original rule filed Aug. 26, 1998, effective July 1, 1999. Amended: Filed Aug. 17, 2000, effective Feb. 28, 2001. Amended: Filed June 14, 2004, effective Dec. 30, 2004. Amended: Filed Dec. 4, 2006, effective May 30, 2007. Amended: Filed Oct. 16, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

PROPOSED AMENDMENT

11 CSR 40-5.120 Inspectors. The Elevator Safety Board is amending sections (1), (2), (4), (5), and (11).

PURPOSE: This amendment is needed due to the fact that the American Society of Mechanical Engineers has discontinued their qualified elevator inspector certification process. The change allows for the acceptance of a national or internationally recognized organization that provides an elevator inspector certification program. The amendment also adds additional causes for action on a license by the Board.

(1) Certification Required. The inspection of all elevator equipment required by sections 701.350–701.380, RSMo and these rules and regulations shall be made only by a licensed inspector certified by the board.

(A) Inspectors certified by the board and directly employed by the state, municipality, political subdivision**,** or authorized representative in a full-time position are exempt from the insurance requirements listed herein, until such time as they perform inspections outside the jurisdiction of the governing authority.

(2) Qualification of Special Inspector. To be eligible for a license to inspect elevator equipment, the applicant or licensee shall—

(A) Have a high school diploma or general educational development (GED) equivalent;

(B) Have had at least four (4) years experience in some mechanical or electrical endeavor, at least one (1) year of which shall have been in the design, construction, installation, repair**,** or inspection of elevators. The non-elevator, mechanical, or electrical experience shall be at the journeyman mechanical level or technical work and the work must have been comparable to work in the elevator industry. Engineering education on a college level may be substituted on a year-for-year basis for the non-elevator qualifying experience. The one (1) year of required elevator experience may be on the basis of continuous employment for one (1) year in which at least half (1/2) of the applicant's time is devoted to elevator work;

(C) Have successfully passed the written examination for elevator inspectors administered by an association accredited by *[the American Society of Mechanical Engineers]* **a nationally or internationally recognized organization** and evidenced by a certification of the applicant or licensee as a qualified elevator inspector (QEI). This is commonly referred to as being QEI certified;

(D) Have submitted proof of insurance coverage insuring the applicant against professional liability, insurance covering the errors and omissions of the applicant and commercial general liability coverage, with an occurrence limit of not less than one (1) million dollars and a general aggregate limit of not less than three (3) million dollars. Additionally, insurance coverage of an employer for whom the special inspector is employed shall be considered to comply with the aforementioned, if the coverage provides equivalent coverage for each special inspector; and

(E) Have no direct financial interest in any business or operation which manufactures, installs, repairs, modifies**,** or services elevator equipment. This qualification does not prohibit employees of insurance companies insuring automatic elevator equipment from obtaining a license as an inspector.

(4) Qualifications of Municipal or Political Subdivision Inspector. To be eligible for a license to inspect elevator equipment for a municipality or political subdivision, the applicant or licensee shall meet the requirements listed in subsections 11 CSR 40-5.120(2)(A), (2)(B), (2)(C)**,** and (2)(E). If applicant or licensee does not meet these requirements then (4)(A), (4)(B), (4)(C)**,** and (4)(F) shall be met*[.]***:**

(A) Have a high school diploma or general educational development (GED) equivalent;

(B) Have had at least one (1) year experience in some mechanical or electrical endeavor. The mechanical or electrical experience shall be at the journeyman mechanical level or technical work and the work must have been comparable to work in the elevator industry. Engineering education on a college level may be substituted on a year-for-year basis for the qualifying experience; *[and]*

(C) Have successfully passed the written examination for elevator inspectors administered by an association accredited by the American Society of Mechanical Engineers and evidenced by a certification of the applicant or licensee as a qualified elevator inspector (QEI). This is commonly referred to as being QEI certified. If applicant or licensee does not meet subsections (4)(A), (4)(B), (4)(C) and (4)(F) then (4)(D), (4)(E), and (4)(F) shall be met*[.]***;**

(D) Have successfully completed the Building Officials Code Administrators (BOCA) certification program for elevator inspector and evidenced by a certification of the applicant or licensee as a BOCA certified elevator inspector*[;]***,** or a nationally recognized elevator certification program approved by the Elevator Safety Board;

(E) Attend one (1) continuing education and certification class per year as approved by the Missouri Elevator Safety Board; and

(F) Have no direct financial interest in any business or operation that manufactures, installs, repairs, modifies**,** or services elevator equipment. This qualification does not prohibit employees of insurance companies insuring automatic elevator equipment from obtaining a license as an inspector. If applicant or licensee does not meet subsections (4)(D), (4)(E)**,** and (4)(F) then section (5) candidate's license requirements shall be met.

(5) Apply for a Candidate's License to the Missouri Elevator Safety Board. To be eligible for and to maintain a candidate's license to inspect elevator equipment for a municipality or political subdivision the applicant shall—

(F) Within five (5) years of the date of application to the Missouri Elevator Safety Board for a candidate's license to inspect elevator equipment the applicant shall have successfully passed the written examination for elevator inspectors administered by an association accredited by the American Society of Mechanical Engineers and evidenced by a certification of the applicant or licensee as a qualified elevator inspector (QEI), commonly referred to as being QEI certified; or have successfully completed the Building Officials Code Administrators (BOCA) certification program for Elevator Inspector and evidenced by a certification of the applicant or licensee as a BOCA certified elevator inspector*[;]***,** or a nationally recognized elevator certification program approved by the Elevator Safety Board; and

(G) Have no direct financial interest in any business or operation that manufactures, installs, repairs, modifies**,** or services elevator equipment. This qualification does not prohibit employees of insurance companies insuring automatic elevator equipment from obtaining a license as an inspector.

(11) Revocation of License.

(A) The board may revoke any license for cause. Such cause includes, but is not limited to the following:

1. Failure to comply with the provisions of sections 701.350–701.380, RSMo, or these rules and regulations;

2. Falsifying or making a material misstatement or omission on any application for license, financial disclosure statement, or inspection report; *[and]*

3. Failure to attend at least one (1) Missouri state elevator code update meeting per calendar year conducted by the department*[.]***; and**

4. Conducting or performing state required safety inspections without a state licensed mechanic, if required.

*AUTHORITY: section 701.355, RSMo [2000] **2016**. Original rule filed Aug. 26, 1998, effective July 1, 1999. Emergency amendment filed Aug. 24, 2000, effective Sept. 4, 2000, expired March 2, 2001. Amended: Filed Aug. 29, 2000, effective Feb. 28, 2001. Amended: Filed Dec. 16, 2002, effective June 30, 2003. Amended: Filed Oct. 16, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies

or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COSTS: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

PROPOSED AMENDMENT

11 CSR 40-5.170 Elevator Mechanic License. The division is amending sections (1) and (2) to remove expired paragraphs (1)(A)1., (1)(A)2., and (2)(A)1. and adding Limited Use/Limited Application elevators and dumbwaiters to the conveyances allowable for work by a Mechanic II licensee.

PURPOSE: This amendment changes the manner in which an elevator mechanic may be licensed and equipment available for installation by Mechanic II licensees.

(1) Elevator Mechanic I—This license authorizes the holder to construct, install, alter, maintain, examine, relocate, test, remove, service, and repair all types of elevators and other conveyances in any location as covered in sections 701.350 to 701.383, RSMo, 11 CSR 40-5.010 to 11 CSR 40-5.195, and American Society of Mechanical Engineers (ASME) A17.1 and ASME A18.1.

(A) Elevator Mechanic I license *[shall]* **may** be granted only to individuals who have demonstrated their qualifications and abilities*[. Applicants shall meet]* **in meeting** one (1) of the following paragraphs:

[1. Furnish the board with acceptable proof the applicant has previously worked as an elevator mechanic for an elevator contractor or as approved by the board, without direct and immediate on-site supervision on equipment covered by A17.1 and A18.1 for a period of no less than four (4) years prior to the effective date of this rule. The person shall make application within one (1) year of the effective date of this rule;

2. Possess a certificate of completion documenting the applicant has successfully passed the mechanic examination of a nationally recognized training program for the elevator industry. The person must make application within one (1) year of the effective date of this rule;]

*[3.]***1.** Possess a certificate of completion of an apprenticeship program registered with the United States Department of Labor's Bureau of Apprenticeship and Training for elevator mechanics;

*[4.]***2.** Applicants with licenses issued by another state shall provide the board documentation that the out-of-state licensing requirements meet or exceed Missouri requirements, and that the license is valid and has not been revoked or suspended; or

*[5.]***3.** *[For an applicant whose experience does not immediately precede their application, the]* **The** board may, at its discretion, issue a license to an applicant who provides documentation *[that]* the applicant has a minimum of four (4) years of prior experience and **acceptable** training, and has successfully passed a mechanic examination of a nationally recognized training program acceptable to the board; and

*[6.]***4.** Upon approval of an application by the board and receipt of the applicable fee, the board *[shall]* **may** issue an elevator mechanic I license *[which will be in effect]* **effective** for a two- (2-) year period from date of issuance or renewal, unless thereafter revoked or suspended.

(2) Elevator Mechanic II—This license authorizes the holder to construct, install, alter, maintain, examine, relocate, test, remove, service, and repair all types of *[elevators and other]* conveyances in any location, as covered in sections 701.350 to 701.383, RSMo, 11 CSR 40-5.010 to 11 CSR 40-5.150, and ASME A18.1**, as well as section 5.2 of ASME A17.1 as it specifically relates to Limited-Use/Limited Application elevators and Section 7 of ASME A17.1 as it specifically relates to dumbwaiters**.

(A) Elevator mechanic II license *[shall]* **may** be granted only to individuals who have demonstrated their qualifications and abilities*[. Applicants shall meet]* **meeting** (1) of the following paragraphs:

[1. Furnish the board with acceptable proof the applicant has previously worked as an elevator mechanic for an elevator contractor or as approved by the board, without direct and immediate on-site supervision on equipment covered by ASME A18.1 for a period of no less than two (2) years prior to the effective date of this rule. The person shall make application within one (1) year of the effective date of this rule;]

*[2.]***1.** Possess a certificate of completion documenting the applicant has successfully passed the mechanic examination of a nationally recognized training program for the elevator industry access products (ASME A18.1) as accepted by the board;

*[3.]***2.** Possess a certificate of completion of an apprenticeship program registered with the United States Department of Labor's Bureau of Apprenticeship and Training for elevator mechanics;

*[4.]***3.** Applicants with licenses issued by another state shall provide the board documentation that the out-of-state licensing requirements meet or exceed Missouri requirements, and that the license is valid and has not been revoked or suspended; or

*[5.]***4.** For an applicant whose experience does not immediately precede their application the board may, at its discretion, issue a license to an applicant who provides documentation acceptable to the board to establish the applicant has sufficient previous training and experience related to the elevator industry; and

*[6.]***5.** Upon approval of an application by the board and receipt of the applicable fee, the board *[shall]* **may** issue an elevator mechanic license II, which will be in effect for a two- (2-) year period from date of issuance or renewal, unless thereafter revoked or suspended.

AUTHORITY: sections 701.355 and 701.377, RSMo [Supp. 2013] ***2016****. Original rule filed Nov. 12, 2014, effective June 30, 2015. Amended: Filed Oct. 16, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Division of Fire Safety, PO Box 844 Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 7—Blasting

PROPOSED AMENDMENT

11 CSR 40-7.010 Blasting—Licensing, Registration, Notification, Requirements, and Penalties. The State Blasting Safety Board, is amending sections (1), (2), (5), and (9).

PURPOSE: This amended rule incorporates changes to the explosives used annual fee structure based upon the passage of SCS HCS HB 1286 (2018) and clarifies location data to be collected for the blast sites and seismograph monitoring devices.

(1) The following definitions shall be used in interpreting this rule:

(A) "Blaster," a person qualified to be in charge of and responsible for the loading and firing of an explosive or explosive material;

(B) "Blast," detonation of explosives;

(C) "Blasting," the use of explosives in mining or construction;

(D) "Blast site," the area where explosives are handled during loading of a bore hole, including fifty feet (50') in all directions from the perimeter formed by loaded holes. A minimum of thirty feet (30') may replace the fifty- (50-)*[-]* foot requirement if the perimeter of loaded holes is marked and separated from non-blast site areas by a barrier. The fifty- (50-)*[-]* foot or thirty- (30-)*[-]* foot distance requirements, as applicable, shall apply in all directions along the full depth of the bore hole;

(E) "Board," the State Blasting Safety Board created in section 319.324, RSMo;

(F) "Bore hole," a hole made with a drill, auger, or other tool in which explosives are placed in preparation for detonation;

(G) "Burden," the distance from an explosive charge to the nearest free or open face at the time of detonation;

(H) "Business day," any day of the week except Saturday, Sunday, or a federal or state holiday;

(I) "Deck," charge of explosives separated from other charges by stemming;

(J) "Delay period," the time delay provided by blasting caps which permits firing of bore holes in sequence;

(K) "Detonation," the action of converting the chemicals in an explosive charge to gases at a high pressure by means of a self-propagating shock wave passing through the charge;

(L) "Detonator," any device containing initiating or primary explosive that is used for initiating detonation of another explosive material. A detonator may not contain more than ten (10) grams of total explosives by weight, excluding ignition or delay charges.The term includes, but is not limited to, electric blasting caps of instantaneous and delay types, blasting caps for use with safety fuse, detonating cord delay connectors, and nonelectric instantaneous and delay blasting caps which use detonating cord, nonelectric shock tube, or any other replacement for electric leg wires;

(M) "Division," the Missouri Division of Fire Safety;

(N) "Direct supervision," to mean the supervisor (blaster) is physically present on the same job site as the person loading or firing the explosives;

(O) "Explosives," any chemical compound, mixture, or device, the primary or common purpose of which is to function by explosion, including, but not limited to, dynamite, black powder, pellet powder, initiating explosives, detonators, millisecond connectors, safety fuses, squibs, detonating cord, igniter cord, and igniters; includes explosive materials such as any blasting agent, emulsion explosive, water gel, or detonator. Explosive materials determined to be within the coverage of sections 319.300 to 319.345, RSMo shall include all such materials listed in Chapter 40 of Title 18 of the *United States Code*, as amended, as issued at least annually by the Department of Justice, Bureau of Alcohol, Tobacco, Firearms and Explosives;

(P) "Firing," causing explosives to be detonated by the use of a fuse, electric detonator, or nonelectric shock tube;

(Q) "Fire protection official," an authorized representative of a municipal fire department, fire protection district, or volunteer fire protection association for the area where blasting occurs;

(R) "Fugitive from justice," any person who has fled from the jurisdiction of any court of record to avoid prosecution for any crime or to avoid giving testimony in any criminal proceeding. The term shall also include any person who has been convicted of any crime and has fled to avoid case disposition;

(S) "Initiation system," components of an explosive charge that cause the charge to detonate, such as primers, electric detonators, and detonating charge;

(T) "Loading," placing of explosives in a hole in preparation for detonation;

(U) "Local government," a city, county, fire protection district, volunteer fire protection association, or other political subdivision of the state;

(V) "Person using explosives," any individual, proprietorship, partnership, firm, corporation, company, or joint venture that is required to hold authority to receive or use explosives under statutes or regulations administered by the U.S. Department of Justice, Bureau of Alcohol, Tobacco, Firearms and Explosives and who employs licensed blasters;

(W) "Scaled distance," a value determined by dividing the linear distance, in feet, from the blast to a specified location, by the square root of the maximum weight of explosives, in pounds, to be detonated in any eight- (8-)*[-]* millisecond period;

(X) "Seismograph," an instrument that measures ground vibration and acoustic effects;

(Y) "Stemming," inert material that is placed above explosives that have been placed in a blast hole in preparation for detonation or vertically between columnar decks of explosives that have been placed in a hole in preparation for detonation; and

(Z) "Uncontrolled structure," any dwelling, public building, school, church, commercial building, or institutional building that is not owned or leased by the person using explosives, or otherwise under the direct contractual responsibility of the person using explosives.

(2) The following fees shall apply for the licensing of blasters, registration of persons using explosives, explosives use reporting, and testing:

(A) Individual Blaster's License: one hundred dollars ($100) for a three- (3-)*[-]* year license;

(B) Registration fee for a person using explosives (one- (1-)*[-]* time fee): two hundred dollars ($200);

(C) Annual explosive use fee: five hundred dollars ($500) plus *[two dollars ($2)]* **five dollars ($5)** per ton of explosives or explosive materials used within the state.

1. When the total pounds of explosive materials used results in a portion of a ton, the tonnage reported shall be rounded to the nearest ton.

2. Per ton fees shall not include any items defined by statute as "detonators"; and

(D) Testing/retesting fee: twenty-five dollars ($25) per individual test.

(5) Each registered person using explosives in Missouri shall, by January 31 of each year after registering, file an annual report with the division for the preceding calendar year.

(D) The person using explosives shall submit with the report, an explosive use fee of five hundred dollars ($500) plus *[two dollars ($2)]* **five dollars ($5)** per ton of explosives or explosive materials used within the state.

(E) Any initial increase of the explosive use fee promulgated by

rule shall be only on those explosives used from July 1 of the calendar year preceding the annual report required in section (5) above unless the report is an initial report pursuant to subsection (5)(A).

1. If the report of total pounds used results in a portion of a ton, the cumulative total of the fee shall be rounded to the nearest ton.

2. In the event that less than one (1) ton of explosives has been used in the reporting period, the five hundred dollar ($500) annual fee shall be submitted with the annual report to the division.

*[(E)]***(F)** The division may audit the records of any person using explosives required to report annually to determine the accuracy of the number of pounds of explosives reported.

*[(F)]***(G)** In connection with such audit, the division may also require any distributor of explosives to provide a statement of sales during the year to persons required to report.

(9) It shall be the duty of each licensed blaster and each person using explosives to assure that the requirements of this section are met.

(F) Each seismograph recording and the accompanying records shall include the—

1. Maximum ground vibration and acoustics levels recorded;

2. Specific **geographic information system data (GIS) of the** location of the seismograph equipment, its distance from the detonation of the explosives, the date of the recording, and the time of the recording;

3. Name of the individual responsible for operation of the seismograph equipment and performing an analysis of each recording; and

4. Type of seismograph instrument, its sensitivity and calibration signal, or certification date of the last calibration.

(J) A record of use of explosives shall be made and retained for at least three (3) years.

1. Licensed blasters shall create the record required in this section and provide such record to the person using explosives, who shall be responsible for maintaining records required in this section.

2. The record shall be completed on a form provided or approved by the division and completed by the end of the business day following the day in which the explosives were detonated.

3. Such records shall be made available to the division, upon request, within twenty four (24) hours of the request.

4. Each record shall include the—

A. Name of the person using the explosives;

B. Location, **geographic information system data (GIS),** date, and time of the detonation;

C. Name of the licensed blaster responsible for use of the explosives;

D. Type of material blasted;

E. Number of bore holes, burden, and spacing;

F. Diameter and depth of bore holes;

G. Type of explosives used;

H. Weight of explosives used per bore hole and total weight of explosives used;

I. Maximum weight of explosives detonated within any eight-(8-)*[-]* millisecond period;

J. Maximum number of bore holes or decks detonated within any eight- (8-)*[-]* millisecond period;

K. Initiation system, including number of circuits and the timer interval, if a sequential timer is used;

L. Type and length of stemming;

M. Type of detonator and delay periods used, in milliseconds;

N. Sketch of delay pattern, including decking;

O. Distance and scaled distance to the nearest uncontrolled structure; and

P. Location of the nearest uncontrolled structure, using the best available information.

5. If the type of blasting being recorded by a seismograph does not involve bore holes, then the record required in paragraph (9)(J)4. shall contain the:

A. Name of the person using the explosives;

B. Location, **geographic information system data (GIS),** date, and time of the detonation;

C. Name of the licensed blaster responsible for use of the explosives;

D. Type of material blasted;

E. Type of explosives used;

F. Weight of explosives used per shot and total weight of explosives used;

G. Maximum weight of explosives detonated within any eight- (8-)*[-]* millisecond period;

H. Initiation system, including number of circuits and the timer interval, if a sequential timer is used;

I. Type of detonator and delay periods used, in milliseconds;

J. Sketch of delay pattern;

K. Distance and scaled distance, if required under the provisions of section 319.309, RSMo, to the nearest uncontrolled structure; and

L. Location of the nearest uncontrolled structure, using the best available information.

AUTHORITY: section 319.306, RSMo 2016. Emergency rule filed April 1, 2008, effective July 1, 2008, expired Jan. 1, 2009. Original rule filed April 2, 2008, effective Jan. 1, 2009. Amended: Filed Oct. 16, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities sixty-five thousand eight hundred ninety-two dollars ($65,892) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Blasting Safety Board, Attn: Administrative Rules, Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: 11 – Department of Public Safety
Division Title: 40 – Division of Fire Safety
Chapter Title: 7 - Blasting

Rule Number and Title:	11 CSR 40-7.010 Blasting---Licensing, Registration, Notification, Requirements, and Penalties
Type of Rulemaking:	Amended Rulemaking

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
85 "Persons using explosives"	**Blasting Companies (Users of Explosives)**	**$66,000 in FY2020**

III. WORKSHEET

$3 (increase) x 21,964 (tons/yr) = $65,892 (~$66,000) per FY.

IV. ASSUMPTIONS

1) Number of companies will not decrease.

2) Amount of explosives used will not significantly decrease.

3) Fees collected at the increased rate shall begin with the FY.

4) The Division of Fire Safety (DFS) is charged with administering the Missouri Explosives Safety Act which regulates and provides oversight of all above-ground blasting conducted in our State. This industry was impacted by the economic downturn in 2009-10, and program revenues have never regained their strength. As a result, the program has struggled with a poor fund balance while supporting two FTE: a blast-safety investigator and one clerical position.

Section 319.318.4(3), RSMo, was revised through the passage of HB 1286 (2018). This bill allowed for the increase in fees per ton of explosives used from $2.00 to up to $7.50 per ton. This amendment would raise the fee to $5.00 per ton used. Pursuant to HB 1286, the fee may not exceed the cost to administer the program.

Following passage of HB 1286, the State Blasting Safety Board, DFS and industry partners agree to an initial increase to $5.00 per ton of explosives used in order to cover the cost of administering the program.

HB 1286 also exempted surface coal mining companies from the blasting fee contained in section 319.318.4(3), RSMo. With the average of 21,924 remaining tons used annually, this fee increase would result in approximately $65,772 of additional revenue annually.

The proposed legislation does allow for an increase up to $7.50 per ton. Section 319.318.4(3), RSMo, requires that the State Blasting Safety Board review the fee schedule on a biennial basis and approve or disapprove adjustments in the fees by rule.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests

PROPOSED AMENDMENT

11 CSR 45-40.010 Definitions. The commission is amending sections (3), (4), and (6); removing section (12); adding new sections (8), and (9); and renumbering accordingly.

PURPOSE: This amendment changes and adds definitions for terms used relating to fantasy sports contests (FSCs) to make the definitions consistent with SB 87, 100th General Assembly.

(3) Fantasy sports contest (FSC)—any fantasy or simulated game or contest with an entry fee*[, conducted on an internet website or any platform,]* in which:

(A) The value of all prizes and awards offered to the winning participants is established and made known in advance of the contest;

(B) All winning outcomes reflect in part the relative knowledge and skill of the participants and are determined predominantly by the accumulated statistical results of the performance of individuals, including athletes in the case of sports events; and

(C) No winning*[s]* outcomes are based on the score, point spread, or any performance of any single actual team or combination of teams or solely on any single performance of an individual athlete or player in any single actual event.

(4) Fantasy sports contest operator (FSCO)—any person *[or]***,** entity**, or division of a corporate entity** that offers *[FSCs for a prize]* **a platform for the playing of fantasy contests, administers one (1) or more fantasy contests with an entry fee, and awards a prize of value**.

(6) Key person—an officer, director, trustee, *[or]* principal salaried executive staff officer**, or any person so designated by the commission or director**.

(8) Location—the geographical position of a person as determined within a degree of accuracy consistent with generally available internet protocol address locators.

(9) Location percentage—for all fantasy sports contests, the percentage, rounded to the nearest one-tenth of one percent (.1%), of the total entry fees collected from registered players located in the state of Missouri at the time of entry into a fantasy contest, divided by the total entry fees collected from all players, regardless of the players' locations, of the fantasy sports contests.

*[(8)]***(10)** Net revenue—for all FSCs, the amount equal to the total entry fees collected from all participants entering such FSCs less winnings paid to participants in the contests, multiplied by the *[resident]* **location** percentage.

*[(9)]***(11)** Officer—the president, vice-president, treasurer, secretary, and other officer identified in an entity's bylaws or incorporation documents, a member or manager of a limited liability company, a sole proprietor, or a partner.

*[(10)]***(12)** Principal salaried executive staff officers—means the president, any vice president in charge of a principal business unit, division, or function (such as sales, administration, or finance), any other officer who performs a policy making function, or any other person who performs similar policy making functions for the FSCO. Executive officers of subsidiaries may be deemed executive officers of the FSCO if they perform such policy making functions for the FSCO.

*[(11)]***(13)** Prize—anything of value including, but not limited to, cash or a cash equivalent, contest credits, merchandise, or admission to another contest in which a prize may be awarded.

[(12) Resident percentage—for all fantasy sports contests, the percentage, rounded to nearest one-tenth of one percent (.1%), of the total entry fees collected from Missouri residents divided by the total entry fees collected from all players, regardless of the players' location, of the fantasy sports contests.]

*AUTHORITY: sections 313.950 and 313.955, RSMo [2016] **Supp. 2019**. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed Oct. 31, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests

PROPOSED AMENDMENT

11 CSR 45-40.020 Application for Fantasy Sports Contest Operator License. The commission is amending sections (1), (2), and (7); adding a new section (4); and renumbering accordingly.

PURPOSE: This amendment incorporates a form for the renewal of a fantasy sports contest operator's license, incorporates amendments to the Fantasy Sports Contest Operator Application, and modifies the rule to be consistent with SB 87, 100th General Assembly.

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material, which is incorporated by reference as a portion of this rule, would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here. The Fantasy Sports Contest Operator Application[and]**,** the FSCO Personal Disclosure Form**, and the FSCO Renewal Form** may also be accessed at http://www.mgc.dps.mo.gov.*

(1) A fantasy sports contest operator (FSCO) license is a license granted by the Missouri Gaming Commission (commission) to allow a person *[or]***,** entity**, or division of a corporate entity** to offer fantasy sports contests (FSCs) for play by **persons located in** Missouri *[residents]* in accordance with the Missouri Fantasy Sports Consumer Protection Act (The Act).

(2) Application for licensure shall be made on the Fantasy Sports Contest Operator Application (application), which the commission adopts and incorporates by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102, and which may be accessed at http://www.mgc.dps.mo.gov. The application does not incorporate any subsequent amendments or additions as adopted by the commission on *[December 7, 2016]* **October 30, 2019**.

(4) Notice of renewal shall be made on the FSCO Renewal Form, which the commission adopted on October 30, 2019 and incorporates by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102, and which may be accessed at http://www.mgc.dps.mo.gov. The FSCO Renewal Form does not incorporate any subsequent amendments or additions.

*[(4)]***(5)** The applicant shall be responsible for keeping the application current at all times. The applicant shall notify the commission in writing within ten (10) days of any changes to any response in the application, and this responsibility shall continue throughout any period during which an application is being considered by the commission. All updates to applications must be submitted by exhibit so that each affected exhibit is resubmitted with the updated information and with the date of resubmission. If any application update is not made in this manner, the commission may deem the update ineffective.

*[(5)]***(6)** The commission may require an affidavit, signed on behalf of the applicant or licensee, to be submitted as an addendum to the Application, regarding matters related to the applicant or licensee or the proposed operation, including, but not limited to, the involvement of any individual in the proposed or licensed operations of the applicant or licensee.

*[(6)]***(7)** No license shall be issued to an applicant until the applicant has provided all of the required forms and requested documents pursuant to this rule.

*[(7)]***(8)** *[The FSCO license expires one (1) year after the date of issuance.]* The licensed FSCO shall submit the **notice of** renewal *[application]* at least *[four (4)]* **two (2)** months prior to the expiration date of the FSCO license.

AUTHORITY: section[s] 313.910, ***RSMo 2016, and sections 313.925, 313.935, 313.950, and 313.955, RSMo [2016] Supp. 2019****. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed Oct. 31, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests

PROPOSED AMENDMENT

11 CSR 45-40.050 Operational Requirements for Fantasy Sports Contest Operators. The commission is adding subsection (1)(H); amending section (4); removing section (3); and renumbering accordingly.

PURPOSE: This amendment adds the requirement for fantasy sports operators to describe the method used to determine the location of a player at time of entry into any fantasy sports contest to be consistent with SB 87, 100th General Assembly.

(1) Each licensed operator shall maintain on file with the commission the following:

(F) A detailed description of its procedures and measures taken to clearly and conspicuously identify highly experienced players in FSC by a symbol attached to a player's username, or by other easily visible means, on the licensed operator's authorized internet website; *[and]*

(G) A detailed description of its online self-exclusion process*[.]***; and**

(H) A detailed description of the method used to determine the geographical position of a player at the time of entry into any FSC.

[(3) Upon request, each licensed operator shall provide the commission with a current and accurate list of Missouri residents who have submitted the operator's online self-exclusion form, which the licensed operator developed pursuant to section 313.920, RSMo.]

*[(4)]***(3)** Each licensed operator shall take commercially and technologically reasonable measures to comply with the provisions of sections 313.915 and 313.920, RSMo, regarding the verification of each FSC player's true identity, date of birth, and address, including, but not limited to, independent verification of age using information obtained from independent sources outside of the player seeking to open an account. Third party services may be used to verify the age **and location** of a player. Each licensed operator shall use such information, at a minimum, to prevent underage individuals from establishing accounts, *[to verify state of residence,]* and to prevent players from establishing more than one (1) account or username or playing anonymously.

*[(5)]***(4)** Upon discovery of a registered account held by a minor, the FSCO shall promptly refund any money held in a minor's account, whether or not the minor has engaged in or attempted to engage in game play. A FSCO may refuse to award a prize to a minor upon a good-faith determination, following reasonable investigation, that the minor misrepresented his or her age in order to enter the FSC, provided, however, that such prize must then be awarded to another participant in the contest who would have won the prize had the minor not participated.

*[(6)]***(5)** Prior to conducting any individually targeted advertising or marketing, but not more than once a week, the licensed operator shall do the following:

(A) Download the current List of Disassociated Persons (DAP List) and the MGC Excluded Persons List from the designated MGC server;

(B) For email marketing campaigns, compare the email addresses from the marketing list to the DAP List and the MGC Excluded Persons List and remove anyone whose email address is found to be on either List (DAP or Excluded);

(C) For direct mail marketing campaigns to non-registered players, search and remove from the marketing list any person who has the same name and address of any person found to be on either List (DAP or Excluded); and

(D) For direct mail marketing campaigns to registered players, search and remove from the marketing list any player who has the same date of birth, first or last name, and address of an individual on either List (DAP or Excluded).

*[(7)]***(6)** If a licensed operator ceases offering fantasy sports contests in Missouri, the licensed operator shall notify the commission of the date of cessation. Notice shall be provided within ten (10) days of the cessation.

AUTHORITY: sections 313.915, 313.920, 313.925, 313.950, and 313.955, RSMo [2016] ***Supp. 2019****. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed Oct. 31, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m. in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests

PROPOSED AMENDMENT

11 CSR 45-40.060 *[Cash Reserve and]* **Segregated Account Requirements**. The commission is amending the title, the purpose, and sections (1), (3), (4), and (5); removing section (2); and renumbering accordingly.

PURPOSE: This amendment changes the requirement that describes how fantasy sports contest operators segregate player funds from operational funds for fantasy sports contest operators to be consistent with SB 87, 100th General Assembly.

PURPOSE: This rule addresses the [minimum cash reserve and] segregated account requirements [and the required procedures and documentation for those reserves and segregated accounts] ***for the protection of player funds****.*

(1) The licensed operator shall maintain *[in the form of cash or cash equivalents the amount of the deposits made to the accounts of Missouri fantasy sports contest players for the benefit and protection of the funds held in such accounts. For purposes of this rule cash equivalents are investments with an original maturity of three (3) months or less]* **a special purpose entity approved by the commission to segregate player funds from operational funds as required by section 313.915, RSMo**.

[(2) Funds held in player accounts of Missouri residents shall be protected as set forth herein. A fantasy sports operator shall maintain a reserve in the form of cash, cash equivalents, or a combination thereof to protect player funds.

(A) The amount of the reserve shall be equal to, at a minimum, the sum of all registered players' funds held in player accounts of Missouri residents.

(B) The reserve agreements must reasonably protect the reserve against claims of the operator's creditors other than the authorized players for whose benefit and protection the reserve is established, and must provide the following:

1. The reserve shall be established and held in trust for the benefit and protection of authorized players to the extent the licensed operator holds money in player accounts for players;

2. The reserve must not be released, in whole or in part, except upon written instruction or approval of the commission. The reserve must be available within ninety (90) days of written demand or written instruction. If the reserve is released to the commission, the commission may interplead the funds in the circuit court of Cole County for distribution to the authorized players for whose protection and benefit the account was established and to the other such persons as the court determines are entitled thereto, or shall take such other steps as necessary to effect the proper distribution of the funds, or may do both;

3. The licensed operator may receive income accruing on the reserve, without obtaining permission from the commission; and

4. The licensed operator has no interest or title to the reserve.

(C) The reserve must be held or issued by a federally insured financial institution and must be established pursuant to a written agreement between the licensed operator and the financial institution.

(D) The proposed reserve arrangement is not effective for purposes of complying with section 313.930.3(4), RSMo, until the commission's written approval has been obtained.

(E) The reserve arrangement agreements may be amended only with the prior written approval of the commission.

(F) The account shall be maintained and controlled by a properly constituted corporate entity that is not the fantasy sports contest operator and whose governing board includes one (1) or more corporate directors who are independent of the fantasy sports contest operator and of any corporation related to or controlled by the fantasy sports contest operator. The corporate entity must meet the following requirements:

1. The corporate entity must require a unanimous vote of all corporate directors to file bankruptcy;

2. The corporate entity must obtain permission from the Missouri Gaming Commission prior to filing bankruptcy or entering into receivership;

3. The corporate entity must have articles of incorporation that prohibit commingling of funds with that of the fantasy sports contest operator except as necessary to reconcile the accounts of players with sums owed by those players to the fantasy sports contest operator;

4. The corporate entity must be restricted from incurring debt other than to fantasy sports players pursuant to the rules that govern their accounts for contests;

5. The corporate entity must be restricted from taking on obligations of the fantasy sports contest operator other than obligations to players pursuant to the rules that govern their accounts for contests; and

6. The corporate entity must be prohibited from dissolving, merging, or consolidating with another company without the written approval of the Missouri Gaming Commission

while there are unsatisfied obligations to fantasy sports contest players.]

*[(3)]***(2)** If, at any time, the *[licensed operator's total available cash and cash equivalent reserve is]* **funds held by the special purpose entity are** less than the amount required by section 313.915, RSMo, the licensee shall notify the commission of this deficiency within forty-eight (48) hours.

*[(4)]***(3)** Each licensed operator shall continuously monitor and maintain a record of all *[player deposits and its cash reserves]* **funds held in player accounts and the amount held by the special purpose entity** to ensure compliance with *[the cash reserves requirement]* **section 313.915, RSMo**.

*[(5)]***(4)** The licensed operator shall provide the commission with documentation of both the amount of *[deposits in players' accounts and the amount in cash reserves]* **funds held in player accounts and the amount held by the special purpose entity** as of the last day of each month by the fifteenth day of the following month.

*AUTHORITY: sections 313.915, 313.950, and 313.955, RSMo [2016] **Supp. 2019**. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed May 31, 2018, effective Jan. 30, 2019. Amended: Filed Oct. 31, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests

PROPOSED AMENDMENT

11 CSR 45-40.070 Operational Fees. The commission is amending section (1).

PURPOSE: This amendment changes the date to submit the Annual Operation Fee report for fantasy sports contest operators to be consistent with SB 87, 100th General Assembly.

(1) The applicant or licensed operator shall file an Annual Operation Fee (AOF) report and all required supporting documentation with the commission by *[January 15]* **September 1** of each year for the previous calendar year. The annual operation fee shall be reported on the AOF report, which the commission *[adopts]* **adopted on October 30, 2019** and incorporates by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102, and which may be accessed at http://www.mgc.dps.mo.gov. The AOF report does not incorporate any subsequent amendments or additions *[as approved by the commission on February 28, 2018]*.

*AUTHORITY: section[s] 313.910, **RSMo 2016, and sections** 313.935, 313.950, and 313.955, RSMo [2016] **Supp. 2019**. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed March 1, 2018, effective Oct. 30, 2018. Amended: Filed Oct. 31, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests

PROPOSED AMENDMENT

11 CSR 45-40.090 Records and Record Retention. The commission is amending sections (1) and (4).

PURPOSE: This amendment changes language to be consistent with SB 87, 100th General Assembly.

(1) Each licensed operator shall maintain complete, accurate, legible, and permanent records of all transactions pertaining to its revenues, expenses, assets, liabilities, and equity. Records shall be sufficient to adequately reflect total entry fees, entry fees collected from **players located in** Missouri *[residents]*, net revenue, winnings paid, prizes awarded, and other fantasy sports contest transactions which accurately reflect the requirements and restrictions contained in this chapter and in Chapter 313, RSMo.

(4) Each licensed operator shall maintain a record, by date, of the total entry fees received from players *[residing]* **located** in the United States, grouped by *[resident]* state, and the total entry fees received from players *[residing]* **located** outside the United States.

*AUTHORITY: section[s] 313.910, **RSMo 2016, and sections** 313.930, 313.950, and 313.955, RSMo [2016] **Supp. 2019**. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed Oct. 31, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests

PROPOSED AMENDMENT

11 CSR 45-40.100 Audits. The commission is amending section (2); removing section (1); and renumbering accordingly.

PURPOSE: This amendment changes language to be consistent with SB 87, 100th General Assembly.

[(1) Independent certified public accountants (C.P.A.s), shall conduct annual financial and authorized internet website audit of each licensed operator.]

*[(2)]***(1)** The annual financial *[and authorized internet website]* audit shall be conducted **by an independent certified public accountant (C.P.A.)** in accordance with generally accepted auditing standards as follows:

(A) Audit the licensed operator's annual financial statements in order to report on the fair representation of such amounts. The C.P.A. shall reconcile these audited amounts to similar amounts on the annual financial reports and system reports; **and**

(B) Audit the annual total entry fees, entry fees from **players located in** Missouri *[residents], [resident]* **location** percentage calculation, winnings paid, net revenue, and the annual operation fee from the most recently filed Annual Operation Fee report, in order to report on the fair representation of such amounts. The C.P.A. shall reconcile these audited amounts to similar amounts on the annual financial reports and system reports*[; and]***.**

[(C) Audit the licensed operator and its authorized internet website for compliance with each requirement set forth in sections 313.900 to 313.955, RSMo, and Chapter 11 CSR 45-40.]

*AUTHORITY: section[s] 313.910, **RSMo 2016, and sections** 313.915, 313.940, 313.950, and 313.955, RSMo [2016] **Supp. 2019**. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed March 1, 2018, effective Oct. 30, 2018. Amended: Filed Oct. 31, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 41—General Tax Provisions

PROPOSED AMENDMENT

12 CSR 10-41.010 Annual Adjusted Rate of Interest. The Director of Revenue proposes to amend section (1) to reflect the interest to be charged on unpaid, delinquent taxes.

PURPOSE: This proposed amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2020.

(1) Pursuant to section 32.065, RSMo, the director of revenue upon official notice of the average predominant prime rate quoted by commercial banks to large businesses, as determined and reported by the Board of Governors of the Federal Reserve System in the Federal Reserve Statistical Release H.15(519) for the month of September of each year has set by administrative order the annual adjusted rate of interest to be paid on unpaid amounts of taxes during the succeeding calendar year as follows:

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%
2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%
2013	3%
2014	3%
2015	3%
2016	3%
2017	4%
2018	4%
2019	5%
2020	**5%**

*AUTHORITY: section 32.065, RSMo 2016. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the **Code of State Regulation**s. Emergency amendment filed Oct. 21, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 21, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Counties	*This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate. The 2020 interest rate imposed on delinquent taxes will be the same as the rate imposed in 2019.*
Cities	
Special Taxing Districts	

III. WORKSHEET

The proposed amendment establishes the rate of interest for 2020 at five percent (5%), remaining the same as the rate in 2019.

The future amount of past due taxes is unknown. With the 2020 interest rate imposed upon delinquent taxes remaining the same as that imposed in 2019, public entities realize no additional fiscal impact. This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

Interest on Delinquent Taxes Paid to Department of Revenue

	Current Rule 5.00%	**Proposed Amendment 5.00%**
Past due tax amount	$100.00	$100.00
Interest Amount (%)	x 5.00	x 5.00
Total Amount Due	**$105.00**	**$105.00**

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the Director of Revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year, as set by the Board of Governors of the Federal Reserve, rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2019 was 5.25 percent.

FISCAL NOTE
PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule:	**Classification by types of the business entities which would likely be affected:**	**Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:**
Any taxpayer with delinquent tax.	Any taxpayer with delinquent tax.	*This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate. The 2020 interest rate imposed on delinquent taxes remains the same as that imposed in 2019. The actual number of affected taxpayers is unknown.*

III. WORKSHEET

The proposed amendment establishes the rate of interest for 2020 at five percent (5%), the same as the rate in 2019.

This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate. Because the 2020 interest rate imposed on delinquent taxes remains at the same rate as that imposed in 2019, the interest rate remains the same on each $100 of delinquent taxes to private entities. The actual number of affected taxpayers is unknown.

Interest on Delinquent Taxes Paid to Department of Revenue

	Current Rule 5.00%	**Proposed Amendment 5.00%**
Past due tax amount	$100.00	$100.00
Interest Amount (%)	x 5.00	x 5.00
Total Amount Due	**$105.00**	**$105.00**

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the Director of Revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year, as set by the Board of

Governors of the Federal Reserve, rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2019 was 5.25 percent.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program

PROPOSED AMENDMENT

13 CSR 70-10.030 Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/IID Services. The division is amending sections (2), (3), (4), (7), (8), and (10), deleting section (6), and renumbering and amending the remaining sections.

PURPOSE: This proposed amendment provides for a rebasing of per diem rates for nonstate-operated intermediate care facilities for individuals with intellectual disabilities (ICF/IID), clarifies the process for determining reimbursement rates, removes and/or replaces obsolete processes and language, and combines and removes duplicative language.

(2) General Principles.

(B) Effective November 1, 1986, the Title XIX per diem rate for all ICF/IID facilities participating on or after October 31, 1986, shall be the lower of—

[1. The average private pay charge;

2. The Medicare per diem rate, if applicable;

3. The rate paid to a facility on October 31, 1986, as adjusted by updating its base year to its 1985 fiscal year. Facilities which do not have a full twelve- (12-) month 1985 fiscal year shall not have their base years updated to their 1985 fiscal years. Changes in ownership, management, control, operation, leasehold interests by whatever form for any facility previously certified for participation in the MO HealthNet program at any time that results in increased capital costs for the successor owner, management, or leaseholder shall not be recognized for purposes of reimbursement; and

4. However, any provider who does not have a rate on October 31, 1986, and whose facility meets the definition in subsection (3)(J) of this rule, will be exempt from paragraph (2)(B)3., and the rate shall be determined in accordance with applicable provisions of this rule.]

1. The Medicare per diem rate, if applicable; or

2. The reimbursement rate as determined in accordance with this regulation.

(E) All illustrations and examples provided throughout this rule are for illustration purposes only and are not meant to be actual calculations.

(3) Definitions.

(A) **"**Allowable cost areas*[.]***" means** *[T]***t**hose cost areas *[which]* **that** are allowable for allocation to the MO HealthNet program based upon the principles established in this rule. The allowability of cost areas, not specifically addressed in this rule, will be based upon criteria of the *Medicare Provider Reimbursement Manual* (HIM-15) and section *[(7)]***(6)** of this rule.

(B) **"**Average private pay charge*[.]***" means** *[T]***t**he *[average private pay charge is the]* usual and customary charge for non-MO HealthNet patients determined by dividing total non-MO HealthNet days of care into total revenue collected for the same service that is included in the MO HealthNet per diem rate, excluding negotiated payment methodologies with the Veterans Administration and the Missouri Department of Mental Health.

[(C) Committee. The advisory committee defined in subsection (6)(A) of this rule.]

*[(D)]***(C) "**Cost report*[.]*" *[The cost report shall detail]* **means a report detailing** the cost of rendering covered services for the fiscal reporting period. Providers must file the cost report on forms provided by and in accordance with the procedures of the *[department]* **Department of Social Services**.

*[(E)]***(D) "**Department*[. The department, unless otherwise specified, refers to]*" **means** the Missouri Department of Social Services**, unless otherwise specified**.

*[(F)]***(E) "**Director*[. The director, unless otherwise specified, refer to]*" **means** the director **of the** Missouri Department of Social Services**, unless otherwise specified**.

*[(G)]***(F) "**Effective *[date.]* **Date" means** *[1. The plan effective date shall be]* November 1, 1986.

[2. The effective date for rate adjustments granted in accordance with section (6) of this rule shall be for dates of service beginning the first day of the month following the director's, or his/her designee's, final determination on the rate.]

*[(H)]***(G) "**ICF/IID*[. Nonstate-operated]*" **means nonstate-operated** facilities certified to provide intermediate care for individuals with intellectual disabilities under the Title XIX program.

*[(I)]***(H) "**Medicare *[rate. This is]* **Rate" means** the allowable cost of care permitted by Medicare standards and principles of reimbursement.

*[(J)]***(I) "**New *[construction. Newly]* **Construction" means newly** built facilities or parts, for which an approved Certificate of Need (CON) or applicable waivers were obtained and which were newly completed and operational on or after November 1, 1986.

*[(K)]***(J) "**New *[owners. Original]* **Owners" means the original** owners of new construction.

*[(L)]***(K) "**Providers*[. A provider]*" **means,** under the Prospective Reimbursement Plan *[is]***,** a nonstate-operated ICF/IID facility with a valid participation agreement, in effect on or after October 31, 1986, with the Missouri Department of Social Services for the purpose of providing long-term care (LTC) services to Title XIX-eligible participants. Facilities certified to provide intermediate care services to individuals with intellectual disabilities under the Title XIX program may be offered a MO HealthNet participation agreement on or after January 1, 1990, only if 1) the facility has no more than fifteen (15) beds for individuals with intellectual disabilities, and 2) there is no other licensed residential living facility for individuals with intellectual disabilities within a radius of one-half (1/2) mile of the facility seeking participation in the MO HealthNet program.

*[(M)]***(L) "**Reasonable and *[adequate reimbursement. Reimbursement]* **Adequate Reimbursement" means reimbursement** levels which meet the needs of an efficiently and economically operated facility and which in no case exceed normal market costs.

*[(N)]***(M) "**Related parties*[. Parties are related when—]*" **means—**

1. An individual or group, regardless of the business structure of either, where, through their activities, one (1) individual's or group's transactions are for the benefit of the other and the benefits exceed those which are usual and customary in the dealings;

2. One (1) or more persons *[has]* **have** an ownership or controlling interest in a party, and the person(s) or one (1) or more relatives of the person(s) has an ownership or controlling interest in the other party. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity, directly or through a subsidiary, operates a facility; or

3. As used in section (3), the following terms mean:

A. **"**Indirect *[ownership/interest]* **Ownership" or "Indirect Interest"** means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. **"**Ownership *[interest]* **Interest"** means the possession of equity in the capital, in the stock, or in the profits of an entity;

C. **"**Ownership *[or controlling interest is when]* **Interest" or "Controlling Interest" means** a person or corporation(s)—

(I) Has an ownership interest *[totalling]* **totaling** five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by an entity, if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from the obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership;

D. **"**Relative**"** means persons related by blood or marriage to the fourth degree of consanguinity; and

E. **"**Entity**"** means any person, corporation, partnership, or association.

*[(O)]***(N) "**Rural *[. Those]***" means those** counties *[which]* **that** are not defined as urban.

*[(P)]***(O) "**Urban *[. The urban counties are]***" means counties that are** standard metropolitan statistical areas including Andrew, Boone, Buchanan, Cass, Christian, Clay, Franklin, Greene, Jackson, Jasper, Jefferson, Newton, Platte, Ray, St. Charles, St. Louis, and St. Louis City.

(4) *[Prospective Reimbursement]* **ICF/IID** Rate Computation. **Except in accordance with other provisions of this rule, the provisions of this section shall apply to all providers of ICF/IID services certified to participate in Missouri's MO HealthNet program. Rate determination shall be based on reasonable and adequate reimbursement levels for allowable cost items described in this rule which are related to ordinary and necessary care for the level-of-care provided for an efficiently and economically operated facility. All providers shall submit documentation of expenses for allowable cost areas. The department shall have authority to require those uniform accounting and reporting procedures and forms as it deems necessary. A reasonable and adequate reimbursement in each allowable cost area will be determined.**

(A) *[Except in accordance with other provisions of this rule, the provisions of this section shall apply to all providers of ICF/IID services certified to participate in Missouri's MO HealthNet program.]* **Prospective Reimbursement Rate Determination through December 31, 2018**.

1. *[ICF/IID facilities*

A. Except in accordance with other provisions of this rule, the MO HealthNet program shall reimburse providers of these LTC services based on the individual MO HealthNet-participant days of care multiplied by the Title XIX prospective per diem rate less any payments collected from participants.] The Title XIX prospective per diem reimbursement rate for the remainder of state Fiscal Year 1987 shall be the facility's per diem reimbursement payment rate in effect on October 31, 1986, as adjusted by updating the facility's allowable base year to its 1985 fiscal year. Each facility's per diem costs as reported on its Fiscal Year 1985 Title XIX cost report will be determined in accordance with the principles set forth in this rule. If a facility has not filed a 1985 fiscal year cost report, **the MO HealthNet Division will use** the most current cost report on file with the department *[will be used]* to set *[its]* **a facility's** per diem rate. Facilities with less than a full twelve-(12-) month 1985 fiscal year will not have their base year rates updated.

*[B.]***2.** For state FY-88 and dates of service beginning July 1, 1987, the negotiated trend factor shall be equal to two percent (2%) to be applied in the following manner: Two percent (2%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1987, shall be added to each facility's rate.

*[C.]***3.** For state FY-89 and dates of service beginning January 1, 1989, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1988, shall be added to each facility's rate.

*[D.]***4.** For state FY-91 and dates of service beginning July 1, 1990, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1990, shall be added to each facility's rate.

5. Prospective payment adjustment (PPA). A FY92 PPA will be provided prior to the end of the state fiscal year for nonstate-operated ICF/IID facilities with a current provider agreement on file with the MO HealthNet Division as of October 1, 1991.

A. For providers that qualify, the PPA shall be the lesser of—

(I) The provider's facility peer group factor (FPGF) times the projected patient days (PPD) covered by the adjustment year times the prospective payment adjustment factor (PPAF) times the nonstate-operated intermediate care facility for individuals with intellectual disabilities ceiling (ICFIIDC) on October 1, 1991 (FPGF × PPD × PPAF × ICFIIDC). For example: A provider having nine hundred twenty (920) paid days for the period May 1991 to July 1991 out of a total paid days for this same period of twenty-eight thousand five hundred sixty-one (28,561) represents an FPGF of three and twenty-two hundredths percent (3.22%). So using the FPGF of 3.22% × 114,244 × 24.5% × $156.01 = $140,607; or

(II) The provider FPGF times one hundred forty-five percent (145%) of the amount credited to the intermediate care revenue collection center (ICRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

B. FPGF—is determined by using each ICF/IID facility's paid days for the service dates in May 1991 through July 1991 as of September 20, 1991, divided by the sum of the paid days for the same service dates for all providers qualifying as of the determination date of October 16, 1991.

C. ICFIIDC—is one hundred fifty-six dollars and one cent ($156.01) on October 1, 1991.

D. PPAF—is equal to twenty-four and one half percent (24.5%) for fiscal year 1992 which includes an adjustment for economic trends.

E. PPD—is the projection of one hundred fourteen thousand two hundred forty-four (114,244) patient days made on October 1, 1991, for the adjustment year.

6. FY-92 trend factor and Workers' Compensation. All facilities with either an interim rate or a prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of eight dollars and eighty-six cents ($8.86) per patient day related to the continuation of the FY-92 trend factor and the Workers' Compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/IID facilities.

7. FY-93 negotiated trend factor. All facilities with either an interim rate or prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of one dollar and sixty-six cents ($1.66) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated

ICF/IID facilities.

*[E.]***8.** FY-96 negotiated trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning January 1, 1996, of six dollars and seven cents ($6.07) per patient day for the negotiated trend factor. This adjustment is equal to four and six-tenths percent (4.6%) of the weighted average per diem rates paid to nonstate-operated ICF/IID facilities on June 1, 1995, of one hundred and thirty-one dollars and ninety-three cents ($131.93).

*[F.]***9.** State FY-99 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1998, of four dollars and forty-seven cents ($4.47) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 1998, of one hundred forty-eight dollars and ninety-nine cents ($148.99).

*[G.]***10.** State FY-2000 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1999, of four dollars and sixty-three cents ($4.63) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on April 30, 1999, of one hundred fifty-four dollars and forty-three cents ($154.43). This increase shall only be used for increases for the salaries and fringe benefits for direct care staff and their immediate supervisors.

*[H.]***11.** State FY-2001 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 2000, of four dollars and eighty-one cents ($4.81) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on April 30, 2000, of one hundred sixty dollars and twenty-three cents ($160.23). This increase shall only be used for increases for salaries and fringe benefits for direct care staff and their immediate supervisors.

*[I.]***12.** State FY-2007 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase of seven percent (7%) to their per diem rates effective for dates of service billed for state fiscal year 2007 and thereafter. This adjustment is equal to seven percent (7%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2006.

*[J.]***13.** State FY-2008 trend factor. Effective for dates of service beginning July 1, 2007, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of two percent (2%) for the trend factor. This adjustment is equal to two percent (2%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2007.

*[K.]***14.** State FY-2009 trend factor. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2008.

*[L.]***15.** State FY-2009 catch up increase. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of thirteen and ninety-five hundredths percent (13.95%). This adjustment is equal to thirteen and ninety-five hundredths percent (13.95%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2008. This increase is intended to provide compensation to providers for the years where no trend factor was given. The catch up increase was based on the CMS PPS Skilled Nursing Facility Input Price Index (four- (4-) quarter moving average).

*[M.]***16.** State FY-2012 trend factor. Effective for dates of service beginning October 1, 2011, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of one and four tenths percent (1.4%) for the trend factor. This adjustment is equal to one and four tenths percent (1.4%) of the per diem rate paid to nonstate-operated ICF/IID facilities on September 30, 2011.

*[N.]***17.** State FY-2014 trend factor. Effective for dates of service beginning January 1, 2014, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF/IID facilities on December 31, 2013.

*[O.]***18.** State FY-2016 trend factor. Effective for dates of service beginning February 1, 2016, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of one percent (1%) for the trend factor. This adjustment is equal to one percent (1%) of the per diem rate paid to nonstate-operated ICF/IID facilities on January 31, 2016.

*[P.]***19.** State FY-2017 trend factor. Effective for dates of service beginning September 1, 2016, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of two percent (2%) for the trend factor. This adjustment is equal to two percent (2%) of the per diem rate paid to nonstate-operated ICF/IID facilities on August 31, 2016.

*[Q.]***20.** State FY-2018 per diem adjustment. Effective for dates of service beginning September 1, 2017, all nonstate-operated ICF/IID facilities shall be subject to a decrease to their per diem rates of two and eighty-two hundredths percent (2.82%). This adjustment is equal to two and eighty-two hundredths percent (2.82%) of the per diem rate paid to nonstate-operated ICF/IID facilities on August 31, 2017.

(B) Per Diem Rate Calculation Effective for Dates of Service Beginning January 1, 2019. Effective for dates of service beginning January 1, 2019, the MO HealthNet Division shall rebase nonstate-operated ICF/IID facilities' per diem rates using the facilities' 2017 fiscal year end cost reports. The rebased rates are contingent upon approval of the state plan amendment by the Centers for Medicare and Medicaid Services.

1. Prospective Rate Calculation.

A. Each nonstate-operated ICF/IID shall have its prospective rate recalculated based on its 2017 fiscal year end cost report using the same principles and methodology as detailed throughout sections (1)-(13) of this regulation.

(I) The costs from the 2017 fiscal year end cost reports shall be trended using the indices from the most recent publication of the Healthcare Cost Review available to the division using the "CMS Nursing Home without Capital Market Basket" table. The costs shall be trended using the four (4) quarter moving average. The costs shall be trended for the years following the cost report year, up to and including the state fiscal year corresponding to the effective date of the rates. For SFY 2019, the trends are as follows:

(a) 2018=3.025%

(b) 2019=2.65%

(II) If a facility's total calculated per diem set forth in this section is less than the facility's current rate, the facility shall continue to receive its current rate.

(III) The division will use the FY 2017 cost report to determine the ICF/IID prospective rate, set forth as follows:

(a) Total Routine Service Cost. Total routine service cost includes patient care, ancillary, dietary, laundry, housekeeping, plant operations, and administration. Each ICF/IID's Title XIX Routine Service Cost per diem shall be calculated as follows:

I. The total routine service costs as reported on the cost report shall be adjusted for minimum utilization, if applicable, trended to the current state fiscal year, and divided by the total patient days to determine the per diem. The minimum utilization adjustment will be determined by applying the unused capacity percent to the sum of the laundry, housekeeping, plant operations, and administration expenses. The following is an illustration of how this item (4)(B)1.A.(III)(a)I. is calculated:

Licensed/Certified Bed Days (9 beds x 365 days)	3,285
Total Patient Days	2,900
Percent Occupied (2,900/3,285)	88%
Bed Days @ Minimum Occupancy of 90% (3,285 x 90%)	2,957
Unused Capacity (90% of Bed Days Less Total Patient Days)	57
Unused Capacity Percent for Minimum Utilization Adjustment(Unused Capacity / 90% of Bed Days)	1.93%
Minimum Utilization Days for Return on Owner's Equity(Greater of 90% of Bed Days or Total Patient Days)	2,957
* Minimum Utilization Adjustment	
Laundry	$5,000
Housekeeping	$8,000
Plant Operations	$46,000
Administration	$165,000
Total Expense	$224,000
Unused Capacity Percent	1.93%
Minimum Utilization Adjustment (Unused Capacity Percent x Total Expense)	$4,323
Patient Care	$400,000
Ancillary	$10,000
Dietary	$25,000
Laundry	$5,000
Housekeeping	$8,000
Plant Operations	$46,000
Administration	$165,000
Total Routine Service Cost	$659,000
Less: Minimum Utilization Adjustment*	($4,323)
Routine Service Cost, Adjusted for Minimum Utilization	$654,677
SFY 2018 Trend	3.025%
SFY 2019 Trend	2.65%
Trended Routine Service Cost	$692,355
Total Patient Days	2,900
Routine Service Cost Per Diem	$238.74

(b) Intermediate Care Facility for Individuals with Intellectual Disabilities Federal Reimbursement Allowance (ICF/IID FRA). The SFY 2019 ICF/IID FRA provider assessment as determined in accordance with 9 CSR 10-31.030 is divided by total patient days to determine the ICF/IID FRA per diem.

I. The following is an illustration of how the ICF/IID FRA assessment is calculated:

SFY 2019 ICF/IID FRA Assessment	$40,000
Total Patient Days	2,900
ICF/IID FRA Per Diem	$13.79

(c) Return on Equity. An owner's net equity consists of investment capital and working capital as indicated in subsection (6)(S). Each ICF/IID's Return on Equity per diem is calculated as follows:

I. Investment Capital. Investment capital includes the investment in building, property, and equipment (cost of land, mortgage payments toward principal, and equipment purchase less the accumulated depreciation).

II. Working Capital. Working capital represents the amount of capital which is required to ensure proper operation of the facility and shall be calculated as 1.1 months of the total expenses less depreciation.

III. The total net equity shall be multiplied by the rate of return as set forth in Section (6)(S) to determine the return on equity. The return on equity is subject to the minimum occupancy percent of 90% in determining the per diem.

IV. The following is an illustration of how this item (4)(B)1.A.(III)(c) is calculated:

Investment Capital	Equipment	Building	Total
Cost	$130,000	$300,000	$430,000
Less: Prior Years Depreciation	($120,000)	($225,000)	($345,000)
Less: Current Year Depreciation	($2,400)	($8,500)	($10,900)
Total Investment Capital	$7,600	$66,500	$74,100

Working Capital	
Total Expenses	$659,000
Less: Current Year Depreciation Expense	($10,900)
	$648,100
Divided by 12 Months	12
	$54,008
Times 1.1 Months	1.1
Total Working Capital	$59,409
Net Equity (Investment Capital + Working Capital)	$133,509
Rate of Return	5.125%
Return on Equity	$6,842
Minimum Utilization Days	2,957
Return on Equity Per Diem	$2.31

(c) Rebased Per-Diem Rate. The total calculated Per-Diem is the sum of the Routine Service Cost per diem, the ICF/IID FRA per diem and the Return on Equity per diem. To determine the rebased per diem rate, the total calculated per diem is compared to the current per diem rate and the facility will be held harmless if the total calculated per diem is less than the current per diem rate (i.e., if the total calculated per diem is less than the current per diem rate, the facility would receive the current per diem).

Routine Service Cost per diem	$238.74
ICF/IID FRA per diem	$13.79
Return on Equity per diem	$2.31
Total Calculated Per Diem	$254.84
Current Per Diem Rate	$200.00
Rebased Per Diem Rate	$254.84

(If the total calculated per diem is less than the current per diem rate, the facility would receive the current per diem rate)

2. Interim Rate Calculation.

A. In the case of a newly certified facility where a valid Title XIX participation agreement has been executed, a request for an interim rate must be submitted in writing to the MO HealthNet Division.

(I) The interim rate shall be determined based on the projected estimated operating costs. The facility's request must specifically and clearly identify the interim rate and be supported by complete and accurate documentation satisfactory to the single state agency. Documentation submitted must include a budget of the projected estimated operating costs. Other documentation may also be required to be submitted upon the request of the division.

(II) The establishment of the prospective rate for all new construction facility providers shall be based on the second full facility fiscal year cost report (i.e., rate setting cost report) prepared in accordance with the principles of this rule. This cost report shall be based on actual operating costs and shall be prepared and submitted in accordance with the reporting requirements in section (7) of this rule.

(III) Prior to establishment of a prospective rate for newly certified facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services or authorized representative to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this rule.

(IV) The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and a prospective reimbursement rate shall be determined on the allowable per diem cost as set forth in section (4) of this rule. The prospective reimbursement rate shall be effective on the first day of the facility's rate setting cost report and payment adjustments shall be made for claims paid at the interim rate.

*[2.]***3.** Adjustments to rates. The prospectively determined reimbursement rate may be adjusted only under the following conditions:

A. When information contained in a facility's cost report is found to be fraudulent, misrepresented, or inaccurate, the facility's reimbursement rate may be reduced, both retroactively and prospectively, if the fraudulent, misrepresented, or inaccurate information as originally reported resulted in establishment of a higher reimbursement rate than the facility would have received in the absence of this information. No decision by the MO HealthNet agency to impose a rate adjustment in the case of fraudulent, misrepresented, or inaccurate information in any way shall affect the MO HealthNet agency's ability to impose any sanctions authorized by statute or rule. The fact that fraudulent, misrepresented, or inaccurate information reported did not result in establishment of a higher reimbursement rate than the facility would have received in the absence of the information also does not affect the MO HealthNet agency's ability to impose any sanctions authorized by statute or rules;

[B. In accordance with subsection (6)(B) of this rule, a newly constructed facility's initial reimbursement rate may be reduced if the facility's actual allowable per diem cost for its first twelve (12) months of operation is less than its initial rate;]

*[C.]***B.** *[When a facility's MO HealthNet reimbursement rate is higher than either its private pay rate or its Medicare rate, the MO HealthNet rate will be reduced in accordance with subsection (2)(B) of this rule]* **Extraordinary circumstances. A participating facility that has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request should be submitted in writing to the division within one (1) year of the occurrence of the extraordinary circumstance. The request should clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment should be supported by complete and accurate documentation satisfactory to the division. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information may be resubmitted once for the requested rate adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, rate adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:**

*[D.]***(I)** When the provider can show that it incurred higher costs due to circumstances beyond its control, and the circumstances are not experienced by the nursing home or ICF/IID industry in general, **and** the *[request must]* **circumstances** have a substantial cost effect*[. These circumstances include, but are not limited to:]***;**

(II) Extraordinary circumstances, which are beyond the reasonable control of the ICF/IID and are not a product or result of the negligence or malfeasance of the ICF/IID, include:

*[(I)]***(a) Unavoidable** *[A]***c**ts of nature*[, such as]* **are natural wild**fire, earthquakes, **hurricane, tornado, lightning,** *[and flood]* **flooding, or other natural disasters for which no one can be held responsible**, that are not covered by insurance **and that occur in a federally declared disaster area**; **or**

*[(II)]***(b)** Vandalism, civil disorder, or both **that are not covered by insurance**; or

*[(III)]***(c)** Replacement of capital depreciable items not built into existing rates that are the result of circumstances not related to normal wear and tear or upgrading of existing system*[;]***.**

[E. When an adjustment to a facility's rate is made in accordance with the provisions of section (6) of this rule; or]

*[F.]***C.** When an adjustment is based on an Administrative Hearing Commission or court decision.

D. New, expanded, or terminated services may be subject to rate review.

E. Disallowance of federal financial participation.

F The following will not be subject to review:

(I) The negotiated trend factor;

(II) The use of prospective reimbursement rate; and

(III) The cost base for the per diem rates except as specified in this rule.

[(B) In the case of newly constructed nonstate-operated ICF/IID facilities entering the MO HealthNet program after October 31, 1986, and for which no rate has previously been set, the director or his/her designee may set an initial rate for the facility as in his/her discretion s/he deems appropriate. The initial rate shall be subject to review by the advisory committee under the provisions of section (6) of this rule.]

(5) Covered Services and Supplies.

(A) ICF/IID services and supplies covered by the per diem reimbursement rate under this plan, and which **the ICF/IID** must *[be provided]* **provide**, as required by federal or state law or rule and include, among other services, the regular room, dietary and nursing services, or any other services that are required for standards of participation or certification. Also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service, and enemas;

2. Items *[which]* **that** are furnished routinely and relatively uniformly to all participants, for example, gowns, water pitchers, soap, basins, and bed pans;

3. Items such as alcohol, applicators, cotton balls, bandaids, and tongue depressors;

4. All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners, and nonlegend vitamins. Any nonlegend drug in one (1) of these four (4) categories must be provided to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; *[all must be provided]* **facilities must provide all** as needed within the existing per diem rate;

5. Items which are utilized by individual participants but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable, nondepreciable medical equipment;

6. Additional items as specified in the appendix to this plan when required by the patient;

7. Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, including dietary supplements written as a prescription item by a physician;

8. All laundry services except personal laundry, which is a noncovered service;

9. All general personal care services *[which are furnished]* **that the facility furnishes** routinely and relatively uniformly to all participants for their personal cleanliness and appearance shall be covered services, for example, necessary clipping and cleaning of fingernails and toenails, basic hair care, shampoos, and shaves to the extent necessary for reasonable personal hygiene. The provider shall not bill the patient or his/her responsible party for this type of personal service;

10. All consultative services as required by state or federal law or regulation or for proper operation by the provider. Contracts for the purchase of these services must accompany the provider cost report. Failure to do so will result in the penalties specified in section *[(9)]***(8)** of this rule;

11. Semiprivate room and board and private room and board when necessary to isolate a participant due to a medical or social condition, such as contagious infection, irrational loud speech, and the like. Unless a private room is necessary due to a medical or social condition, a private room is a noncovered service, and a MO HealthNet participant or responsible party may therefore pay the difference between a facility's semiprivate charge and its charge for a private room. MO HealthNet participants may not be placed in private rooms and charged any additional amount above the facility's MO HealthNet per diem unless the participant or responsible party in writing specifically requests a private room prior to placement in a private room and acknowledges that an additional amount not payable by MO HealthNet will be charged for a private room;

12. Twelve (12) days per any period of six (6) consecutive months during which a participant is on a temporary leave of absence from the facility. *[Temporary leave of absence days must be specifically provided for]* **The provider shall specifically provide for temporary leave of absence days** in the participant's plan of care. Periods of time during which a participant is away from the facility because s/he is visiting a friend or relative are considered temporary leaves of absence; and

13. Days when participants are away from the facility overnight on facility-sponsored group trips under the continuing supervision and care of facility personnel.

[(6) Rate Determination. All nonstate-operated ICF/IID providers of LTC services under the MO HealthNet program who desire to have their rates changed or established must apply to the MO HealthNet Division. The department may request the participation of the Department of Mental Health in the analysis for rate determination. The procedure and conditions for rate reconsideration are as follows:

(A) Advisory Committee. The director, Department of Social Services, shall appoint an advisory committee to review and make recommendations pursuant to provider requests for rate determination. The director may accept, reject, or modify the advisory committee's recommendations.

1. Membership. The advisory committee shall be composed of four (4) members representative of the nursing home industry in Missouri, three (3) members from the Department of Social Services, and two (2) members which may include, but are not limited to, a consumer representative, an accountant or economist, or a representative of the legal profession. Members shall be appointed for terms of twelve (12) months. The director shall select a chairman from the membership who shall serve at the director's discretion.

2. Procedures.

A. The committee may hold meetings when five (5) or more members are present and may make recommendations to the department in instances where a simple majority of those present and voting concur.

B. The committee shall meet no less than one (1) time each quarter, and members shall be reimbursed for expenses.

C. The MO HealthNet Division will summarize each case and, if requested by the advisory committee, make recommendations. The advisory committee may request additional documentation as well as require the facility to submit to a comprehensive operational review to determine if there exists an efficient and economical delivery of patient services. The review will be made at the discretion of the committee and may be performed by it or its designee. The findings from a review may be used to determine the per diem rate for the facility. Failure to submit requested documentation shall be grounds for denial of the request.

D. The committee, at its discretion, may issue its recommendation based on written documentation or may request further justification from the provider sending the request.

E. The advisory committee shall have ninety (90) days from the receipt of each complete request, provided the request is on behalf of a facility which has executed a valid Title XIX participation agreement, or the receipt of any additional documentation to submit its recommendations in writing to the director. If the committee is unable to make a recommendation within the specified time limit, the director or his/her designee, if the committee establishes good cause, may grant a reasonable extension.

F. Final determination on rate adjustment. The director's, or his/her designee's, final decision on each request shall be issued in writing to the provider within fifteen (15) working days from receipt of the committee's recommendation.

G. The director's, or his/her designee's, final determination on the advisory committee's recommendation shall become effective on the first day of the month in which the request was made, providing that it was made prior to the tenth of the month. If the request is not filed by the tenth of the month, adjustments shall be effective the first day of the following month;

(B) In the case of new construction where a valid Title XIX participation agreement has been executed, a request for a rate must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total amount involved. The total dollar amount must be supported by complete, accurate, and documented records satisfactory to the single state agency. Until an initial per diem rate is established, the MO HealthNet Division shall

grant a tentative per diem rate for that period. In no case may a facility receive a per diem reimbursement rate greater than the class ceiling in effect on March 1, 1990, adjusted by the negotiated trend factor.

1. In the case of newly built facility or part of the facility which is less than two (2) years of age and enters the Title XIX Program on or after November 1, 1986, a reimbursement rate shall be assigned based on the projected estimated operating costs. Advice of the advisory committee will be obtained for all initial rate determination requests for new construction. Owners of new construction which have an approved CON are certified for participation and which have a valid Title XIX participation agreement shall submit a budget in accordance with the principles of section (7) of this rule and other documentation as the committee may request.

2. The establishment of the permanent rate for all new construction facility providers shall be based on the second full facility fiscal year cost report prepared in accordance with the principles of section (7) of this rule. This cost report shall be submitted within ninety (90) days of the close of their second full facility fiscal year. This cost report shall be based on actual operating costs. No request for an extension of this ninety- (90-) day filing requirement will be considered. Any new construction facility provider which fails to timely submit the cost report may be subject to sanction under this rule and 13 CSR 70-3.030.

3. Prior to establishment of a permanent rate for new construction facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this rule.

4. The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and each facility's actual allowable per diem cost will be determined. The cost report shall not be submitted to the advisory committee for review. If a facility's actual allowable per diem cost is less than its initial per diem reimbursement rate, the facility's rate will be reduced to its actual allowable per diem cost. This reduction will be effective on the first day of the second full facility fiscal year.

5. If a facility's actual allowable per diem cost is higher than its initial per diem reimbursement rate, the facility's rate will not be adjusted; a facility shall not receive a rate increase based on review or audit of the cost report and actual operating costs;

(C) In the case of existing facilities not previously certified to participate in the Title XIX program, a request for a per diem reimbursement rate must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total amount involved. The total dollar amount must be supported by complete, accurate, and documented records satisfactory to the single state agency. Until the time as a per diem rate is established, the MO HealthNet Division shall grant a tentative per diem rate for that period. In no case may a facility receive a per diem reimbursement rate greater than the class ceiling in effect on March 1, 1990, adjusted by the negotiated trend factor.

1. In the case of a facility described in subsection (6)(C) of this rule and entering the Title XIX program on or after March 1, 1990, a reimbursement rate shall be assigned based on the projected estimated operating costs. Advice of the advisory committee will be obtained for all initial rate determination requests for first full facility's fiscal year.

2. The establishment of the permanent rate for all existing facility providers shall be based on the second full facility fiscal year cost report prepared in accordance with the principles of section (7) of this rule. This cost report shall be submitted within ninety (90) days of the close of their second full facility fiscal year. This cost report shall be based on actual operating costs. No request for an extension of this ninety- (90-) day filing requirement will be considered. Any new construction facility provider which fails to timely submit the cost report may be subject to sanction under this rule and 13 CSR 70-3.030.

3. Prior to establishment of a permanent rate for existing facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this rule.

4. The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and each facility's actual allowable per diem cost will be determined. The cost report shall not be submitted to the advisory committee for review. If a facility's actual allowable per diem cost is less than its initial per diem reimbursement rate, the facility's rate will be reduced to its actual allowable per diem cost. This reduction will be effective on the second day of the first full facility fiscal year.

5. If a facility's actual allowable per diem cost is higher than its initial per diem reimbursement rate, the facility's rate will not be adjusted; a facility shall not receive a rate increase based on review or audit of the cost report and actual operating costs;

(D) Rate Reconsideration.

1. The committee may review the following conditions for rate reconsideration:

A. Those costs directly related to a change in a facility's case mix; and

B. Requests for rate reconsideration which the director, in his/her discretion, may refer to the committee due to extraordinary circumstances contained in the request and as defined in subparagraph (4)(A)2.D. of this rule.

2. The request for an adjustment must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by complete, accurate, and documented records satisfactory to the single state agency. The facility must demonstrate that the adjustment is necessary, proper, and consistent with efficient and economical delivery of covered patient care services.

3. However, for state fiscal years after Fiscal Year 1987, in no case may a facility receive a per diem reimbursement rate higher than the class ceiling for that facility in effect on June 30 of the preceding fiscal year adjusted by the negotiated trend factor.

4. The following will not be subject to review:

A. The negotiated trend factor;

B. The use of prospective reimbursement rate; and

C. The cost base for the June 30 per diem rate except as specified in this rule;

(E) Rate Adjustments. The department may alter a facility's per diem rate based on—

1. Court decisions;

2. Administrative Hearing Commission decisions;

3. Determination through desk audits, field audits, and other means, which establishes misrepresentations in or the inclusion of unallowable costs in the cost report used to establish the per diem rate. In these cases, the adjustment shall be applied retroactively; or

4. Adjustments determined by the department without the advice of the rate advisory committee.

A. Prospective payment adjustment (PPA). A FY-92 PPA will be provided prior to the end of the state fiscal year for nonstate-operated ICF/IID facilities with a current provider agreement on file with the MO HealthNet Division as of October 1, 1991.

(I) For providers which qualify, the PPA shall be the lesser of—

(a) The provider's facility peer group factor (FPGF) times the projected patient days (PPD) covered by the adjustment year times the prospective payment adjustment factor (PPAF) times the nonstate-operated intermediate care facility for individuals with intellectual disabilities ceiling (ICFIIDC) on October 1, 1991 (FPGF × PPD × PPAF × ICFIIDC). For example: A provider having nine hundred twenty (920) paid days for the period May 1991 to July 1991 out of a total paid days for this same period of twenty-eight thousand five hundred sixty-one (28,561) represents an FPGF of three and twenty-two hundredths percent (3.22%). So using the FPGF of 3.22% × 114,244 × 24.5% × $156.01 = $140,659; or

(b) The provider FPGF times one hundred forty-five percent (145%) of the amount credited to the intermediate care revenue collection center (ICRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

(II) FPGF—is determined by using each ICF/IID facility's paid days for the service dates in May 1991 through July 1991 as of September 20, 1991, divided by the sum of the paid days for the same service dates for all provider's qualifying as of the determination date of October 16, 1991.

(III) ICFIIDC—is one hundred fifty-six dollars and one cent ($156.01) on October 1, 1991.

(IV) PPAF—is equal to twenty-four and five-tenths percent (24.5%) for fiscal year 1992 which includes an adjustment for economic trends.

(V) PPD—is the projection of one hundred fourteen thousand two hundred forty-four (114,244) patient days made on October 1, 1991, for the adjustment year;

5. FY-92 trend factor and Workers' Compensation. All facilities with either an interim rate or a prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of eight dollars and eighty-six cents ($8.86) per patient day related to the continuation of the FY-92 trend factor and the Workers' Compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/IID facilities; or

6. FY-93 negotiated trend factor. All facilities with either an interim rate or prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of one dollar and sixty-six cents ($1.66) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/IID facilities; and

(F) Rate determination shall be based on a determination of reasonable and adequate reimbursement levels for allowable cost items described in this rule which are related to ordinary and necessary care for the level-of-care provided for an efficiently and economically operated facility. All providers shall submit documentation of expenses for allowable cost areas. The department shall have authority to require those uniform accounting and reporting procedures and forms as it deems necessary. A reasonable and adequate reimbursement in each allowable cost area will be determined by the advisory committee with the consent of the director.]

*[(7)]***(6)** Allowable Cost Areas.

(A) Compensation of Owners.

1. Allowance of compensation of services of owners shall be an allowable cost area, provided the *[services are actually performed]* **owner actually performs the services** and **the services** are necessary *[services]*.

2. **"**Compensation**"** *[shall mean]* **means** the total benefit **to the owner**, within the limitations set forth in this rule, *[by the owner]* of the services s/he renders to the facility *[including]***. Compensation includes** direct payments **to the owner** for managerial, administrative, professional, and other services*[,]***;** amounts paid by the provider for the personal benefit of the owner*[,]***;** the cost of assets and services *[which]* **that** the owner receives from the provider*[,]***;** and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described.

3. *[Reasonableness]* **MO HealthNet auditors may determine the reasonableness** of compensation *[may be determined by]* by reference to or in comparison with compensation paid for comparable institutions or it may be determined by other appropriate means such as the *Medicare and Medicaid Provider Reimbursement Manual* (HIM-15) or by other means.

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility, had the provider not rendered these services, then employment of another person(s) to perform the service would be necessary.

(B) Covered services and supplies as defined in section (5) of this rule.

(C) Depreciation.

1. An appropriate allowance for depreciation on buildings, furnishings, and equipment *[which]* **that** are part of the operation and sound conduct of the provider's business is an allowable cost item. Finder's fees are not an allowable cost item.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the asset and prorated over the estimated useful life of the asset using the straight-line method of depreciation from the date initially put into service.

3. The basis of assets at the time placed in service shall be the lower of—

A. The book value of the provider;

B. Fair market value at the time of acquisition;

C. The recognized Internal Revenue Service (IRS) tax basis; and

D. In the case of the change in ownership, the cost basis of acquired assets of the owner of record on or after July 18, 1984, as of the effective date of the change of ownership; or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program.

4. The **MO HealthNet Division will allow the** basis of donated assets *[will be allowed]* to the extent of *[recognition of income resulting]* **the recognized income resulting** from the donation of the asset. Should a dispute arise between a provider and the Department of Social Services as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the MO HealthNet program and the facility in ratio to MO HealthNet participant reimbursable patient days to total patient days.

5. Allowable methods of depreciation shall be limited to the straight-line method. The depreciation method used for an asset under the MO HealthNet program need not correspond to the method used by a provider for non-MO HealthNet purposes; however, useful life shall be in accordance with the American Hospital Association's Guidelines. Component part depreciation is optional and allowable under this plan.

6. **"**Historical cost**"** *[is]* **means** the cost incurred by the provider in acquiring the asset and preparing it for use, except as provided in this rule. Usually, historical cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees and related legal fees. Where a provider has elected, for federal income tax purposes, to expense certain items such as interest and taxes during construction, the historical cost basis for MO HealthNet depreciation purposes may include the amount of these expensed items. However, where a provider did not capitalize these costs and has written off the costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For Title XIX purposes and this rule, any asset costing less than five hundred dollars ($500) or having a useful life of one (1) year or less, may be expensed and not capitalized at the option of the provider, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program.

7. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of **the** undepreciated cost basis of the traded asset plus the cash paid.

8. For the purpose of determining allowance for depreciation, the cost basis of the asset shall be as prescribed in paragraph *[(7)]***(6)**(C)3.

9. Capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a provider's bed capacity shall not be allowed in the program or depreciation base if these capital expenditures fail to comply with any other federal or state law or regulation, such as Certificate of Need (CON).

10. Amortization of leasehold rights and related interest and finance costs shall not be allowable costs under this plan.

(D) Interest and Finance Costs.

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost item excluding finder's fees.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for those purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as **the** acquisition of facilities and capital improvements, and this indebtedness must be amortized over the life of the loan.

3. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. To be an allowable cost item, interest (including finance charges, prepaid costs, and discounts) must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required, identifiable in the provider's accounting records, relating to the reporting period in which the costs are claims, and necessary and proper for the operation, maintenance, or acquisition of the provider's facilities.

5. Necessary means that the interest be incurred for a loan made to satisfy a financial need of the provider and for a purpose related to participant care. Loans *[which]* **that** result in excess funds or investments are not considered necessary.

6. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made, and provided further the department shall not reimburse for interest and finance charges any amount in excess of the prime rate current at the time the loan was obtained.

7. Interest on loans to providers by proprietors, partners, and any stockholders shall not be an allowable cost item because the loans shall be treated as invested capital and included in the computation of an allowable return on owner's net equity. If a facility operated by a religious order borrows from the order, interest paid to the order shall be an allowable cost.

8. If loans for capital indebtedness exceed the asset cost basis as defined in subsection *[(7)]***(6)**(C) of this rule, the interest associated with the portion of the loan(s) which exceed the asset cost basis as defined in subsection *[(7)]***(6)**(C) of this rule shall not be allowable.

9. Income from a provider's qualified retirement fund shall be excluded in consideration of the per diem rate.

10. A provider shall amortize finance charges, prepaid interest, and discount over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance.

11. Usual and customary costs, excluding finder's fees, incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the loan period ratably or by means of the constant interest applied method.

12. Usual and customary costs shall be limited to the lender's title and recording fees, appraisal fees, legal fees, escrow fees, and closing costs.

13. Interest expense resultant from capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a bed capacity by the provider shall not be an allowable cost item if the capital expenditure fails to comply with other federal or state law or rules such as CON.

(E) Rental and Leases.

1. Rental and leases of land, buildings, furnishings, and equipment are allowable cost areas *[provided that]* **if** the rented items are necessary and not in essence a purchase of those assets. Finder's fees are not an allowable cost item.

2. Necessary rental and lease items are those *[which]* **that** are pertinent to the economical operation of the provider.

3. In the case of related parties, rental and lease amounts cannot exceed the lesser of those *[which]* **that** are actually paid or the costs to the related party.

4. Determination of reasonable and adequate reimbursement for rental and amounts, except in the case of related parties *[which]* **that** is subject to other provisions of this rule, may require affidavits of competent, impartial experts who are familiar with the current rentals and leases.

5. The test of necessary costs shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

6. Leases subject to CON approval must have that approval before a rate is determined.

7. If rent or lease costs increase solely as a result of change in ownership, the resulting increase which exceeds the allowable capital cost of the owner of record as of July 18, 1984, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program, shall be a nonallowable cost.

(F) Taxes. Taxes levied on or incurred by providers shall be allowable cost areas with the exceptions of the following items:

1. Federal, state, or local income and excess profit taxes including any interest and penalties paid;

2. Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bond, property transfer, issuance of transfer of stocks;

3. Taxes for which exemptions are available to the provider;

4. Special assessments on land *[which]* **that** represent capital improvements. These costs shall be capitalized and depreciated over the period during which the assessment is scheduled to be paid;

5. Taxes on property which are not a part of the operation of the provider;

6. Taxes which are levied against a resident and collected and remitted by the provider; and

7. Self-employment Federal Insurance Contributions Act (FICA) taxes applicable to individual proprietors, partners, or members of a joint venture to the extent the taxes exceed the amount which would have been paid by the provider on the allowable compensation of the persons had the provider organization been an incorporated rather than unincorporated entity.

(G) Issuance of Revenue Bond and Tax Levies by District and County Facilities. Those nursing home districts and county facilities whose funding is through the issuance of revenue bonds, that interest which is paid per the revenue bond will be an allowable cost item. Depreciation on the plant and equipment of these facilities also shall be an allowable cost item. Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset except to the extent that the funds are used for the actual operation of the facility.

(H) Value of Services of Employees.

1. Except as provided for in this rule, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers, such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals, and similar organizations, shall not be included as an allowable cost area, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis, and similar type professionals shall be an allowable cost area; provided, that the services are not of a religious nature. An example of an allowable cost area under this section would be a necessary administrative function performed by a clergyman. The state will not recognize building costs on space set aside primarily for professionals providing any religious function. *[Costs]* **The MO HealthNet Division considers costs** for wardrobe and similar items likewise *[are considered]* nonallowable.

(I) Fringe Benefits.

1. Life insurance.

A. Types of insurance *[which are not considered]* **that the MO HealthNet Division does not consider** an allowable cost area; premiums related to insurance on the lives of officers and key employees are not allowable cost areas under the following circumstances:

(I) Where, upon the death of an insured officer or key employee, the insurance proceeds are payable directly to the provider. In this case, the provider is a direct beneficiary. Insurance of this type is referred to as key-man insurance; and

(II) Where insurance on the lives of officers is voluntarily taken out as part of a mortgage loan agreement entered into for building construction and, upon the death of an insured officer, the proceeds are payable directly to the lending institution as a credit against the loan balance. In this case, the provider is an indirect beneficiary.

B. Types of insurance which are considered an allowable cost area—

(I) Where credit life insurance is required as part of a mortgage loan agreement. An example would be insurance on loans granted under certain federal programs; and

(II) Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. *[This type of insurance is considered to be]* **The MO HealthNet Division considers this type of insurance** a fringe benefit and is an allowable cost area to the extent that the amount of coverage is reasonable.

2. Retirement plans.

A. Contributions to qualified retirement plans for the benefit of employees excluding stockholders, partners, and proprietors of the provider shall be allowable cost areas. *[Interest]* **Facilities shall exclude interest** income from funded pensions or retirement plans *[shall be excluded]* from consideration in determining the allowable cost area.

B. Amounts funded to pension and retirement plans, together with associated income, shall be recaptured if not actually paid when due, as an offset to expenses on the cost report form.

3. Deferred compensation plans.

A. Contributions for the benefit of employees, excluding stockholders, partners, and proprietors, under deferred compensation plans shall be all allowable cost areas when, and to the extent that, the costs are actually paid by the provider. Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans will be considered as an allowable cost area only when paid to the participating employee and only to the extent considered reasonable.

B. Amounts paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans, together with associated income *[shall be recaptured]* if not actually paid when due, as an offset to expenses on the cost report form.

(J) Education and Training Expenses.

1. The cost of on-the-job training *[which]* **that** directly benefits the quality of health care or administration at the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is an allowable cost item only when specifically authorized in advance by the department.

2. Cost of education and training shall include incidental travel costs, but will not include leaves of absence or sabbaticals.

(K) Organizational Cost Items.

1. Organizational cost items may be included as an allowable cost area on an amortized basis.

2. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations, necessary accounting fees, expenses of temporary directors, and organizational meetings of directors and stockholders, and fees paid to states of incorporation.

3. *[Organizational costs shall be amortized]* **The provider shall amortize organizational costs** ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

4. Where a provider did not capitalize organizational costs and has written off those costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program.

5. Where a provider is organized within a five- (5-) year period prior to entering the program and has properly capitalized organizational costs using a sixty- (60-) month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost area under the program and shall be amortized over the remaining part of the sixty- (60-) month period.

6. For change in ownership after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost.

(L) Advertising Costs. Advertising costs *[which]* **that** are reasonable, appropriate, and helpful in developing, maintaining, and furnishing services shall be an allowable cost area. The costs must be common and accepted occurrence in the field of the activity of the provider.

(M) Cost of Suppliers Involving Related Parties. Costs applicable to facilities, goods, and services furnished to a provider by a supplier related to the provider shall not exceed the lower of the cost to the supplier or the prices of comparable facilities, goods, or services obtained elsewhere. A provider shall identify suppliers related to it in the uniform cost report and the type-quantity and costs of facilities, goods, and services obtained from each supplier.

(N) Utilization Review. Incurred cost for the performance of required utilization review for ICF/IID is an allowable cost area. The expenditures must be for *[the purpose of]* providing utilization review on behalf of a Title XIX participant. *[Utilization]* **The provider shall apportion utilization** review costs incurred for Title XVIII and Title XIX *[must be apportioned on the basis of]* **based on** reimbursable participant days recorded for each program during the reporting period.

(O) Minimum Utilization. In the event the occupancy of a provider is below ninety percent (90%), the **provider will calculate the** following cost centers *[will be calculated]* as if the provider experienced ninety percent (90%) occupancy: laundry, housekeeping, general, administrative, and plant operation costs. In no case may **the provider carry forward** costs disallowed under this provision *[be carried forward]* to succeeding periods.

(P) Nonreimbursable Costs.

1. Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included as allowable costs.

2. Those services that are specifically provided by Medicare and MO HealthNet must be billed to those agencies.

3. Any costs incurred that are related to fund drives are not reimbursable.

4. Costs incurred for research purposes shall not be included as allowable costs.

5. The cost of services provided under the Title XX program, by contract or subcontract, is specifically excluded as an allowable item.

6. Attorney fees related to litigation involving state, local, or federal governmental entities and attorneys' fees which are not related to the provision of LTC services, such as litigation related to disputes between or among owners, operators, or administrators.

7. Costs, such as legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition of merger for which any payment has been previously made under the program.

(Q) Other Revenues. Other revenues, including those listed that follow and excluding amounts collected under paragraph (5)(A)8. will be deducted from the total allowable cost and must be shown separately in the cost report by use of a separate schedule if included in the gross revenue: income from telephone services; sale of employee and guest meals; sale of medical abstracts; sale of scrap and waste food or materials; rental income; cash, trade, quantity time, and other discounts; purchase rebates and refunds; recovery on insured loss; parking lot revenues; vending machine commissions or profit; sales from drugs to other than participants; income from investments of whatever type; and room reservation charges for temporary leave of absence days which are not covered services under section (5) of this rule. Failure **by the provider** to**, in a readily ascertainable manner,** separately account for any of the revenues specifically set out previously *[in this rule in a readily ascertainable manner]* **in this rule,** shall result in **the provider's** termination from the program.

1. Interest income received from a funded depreciation account will not be deducted from allowable operating costs *[provided that]* **if** interest is applied to the replacement of the asset being depreciated.

2. Cost centers or operations specified by the provider in *[paragraph (7)(R)3.]* **subsection (6)(R)** of this rule shall not have their associated cost or revenues included in the covered costs or revenues of the facility.

3. Restricted and unrestricted funds.

A. **"**Restricted funds**,"** as used in this rule**,** mean those funds, cash or otherwise, including grants, gifts, taxes, and income from endowments, which **the provider** *[must be used only]* **shall only use** for a specific purpose designated by the donor. Those restricted funds *[which]* **that** are not transferred funds and are designated by the donor for paying operating costs will be offset from the total allowable expenses. If an administrative body has the authority to re-restrict restricted funds designated by the donor for paying operating costs, the *[funds]* **provider** will not *[be]* offset **the funds** from **the** total allowable expenses.

B. **"**Unrestricted funds**,"** as used in this rule**,** mean those funds, cash or otherwise, including grants, gifts, taxes, and income from endowments, that *[are given]* **a donor gives** to a provider without restriction *[by the donor]* as to their use. *[These funds can be used]* **The provider can use these funds** in any manner *[desired by the provider]*. However, those unrestricted funds *[which]* **that** are not transferred funds and *[are used for paying]* **that the provider uses to pay** operating costs will be offset from total allowable expenses.

C. Transferred funds**,** as used in this rule**,** are those funds appropriated through a legislative or governmental administrative body's action, state or local, to a state or local government provider. The transfer can be state-to-state, state-to-local, or local-to-local provider. *[These funds are not considered]* **The MO HealthNet Division does not consider these funds** a grant or gift for reimbursement purposes, so *[having]* **have** no effect on the provider's allowable cost under this plan.

(R) Apportionment of Costs to MO HealthNet Participant Residents.

1. *[Provider's]* **Providers shall apportion their** allowable cost areas *[shall be apportioned]* between MO HealthNet program participant residents and other *[patients]* **residents** so that the share **of allowable cost areas** borne by the MO HealthNet program is based upon actual services received by **MO HealthNet** program participants.

2. To accomplish this apportionment, **providers shall apply** the ratio of *[participant residents' charges]* **patient days for MO HealthNet participants** to **the** total patient *[charges for the service of each ancillary department may be applied to the cost of this department. To this shall be added the cost of routine services for MO HealthNet program participant residents determined on the basis of a separate average cost per diem for general routine care areas or at the option of the provider on the basis of overall routine care area.*

3. So that its charges may be allowable for use in apportioning costs under the program, each provider shall have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonable and consistently related to the cost of providing these services] **days**.

*[4.]***3.** Average cost per diem for general routine services means the amount computed by dividing the total allowable patient costs for routine services by the total number of patient days of care rendered by the provider in the cost-reporting period.

*[5.]***4.** A patient day of care is that period of service rendered a patient between the census-taking hours on two (2) consecutive days, including the twelve (12) temporary leave of absence days per any period of six (6) consecutive months as specifically covered under section (5) of this rule, the day of discharge being counted only when the patient was admitted the same day. *[A census log shall be maintained]* **The provider shall maintain a census log** in the facility for documentation purposes. Census shall be taken daily at midnight. A day of care includes those overnight periods when a participant is away from the facility on a facility-sponsored group trip and remains under the supervision and care of facility personnel.

*[6.]***5.** ICF/IID facilities that provide intermediate care services to MO HealthNet participants may establish distinct part cost centers in their facility provided that adequate accounting and statistical data

required to separately determine the nursing care cost of each distinct part is maintained. Each distinct part may share the common services and facilities, such as management services, dietary, housekeeping, building maintenance, and laundry.

*[7.]***6.** In no case may a provider's allowable costs allocated to the MO HealthNet program include the cost of furnishing services to persons not covered under the MO HealthNet program.

(S) Return on Equity.

1. A return on a provider's net equity shall be an allowable cost area.

2. The amount of return on a provider's net equity shall *[not exceed twelve percent (12%)]* **be calculated using the nursing home allowable percentage as defined in 13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services**.

3. An owner's net equity is comprised of investment capital and working capital. Investment capital includes the investment in building, property, and equipment (cost of land, mortgage payments toward principle, and equipment purchase less the accumulative depreciation). Working capital represents the amount of capital *[which]* **that** is required to *[insure]* **ensure** proper operation of the facility.

4. The return on owner's net equity shall be payable only to proprietary providers.

5. *[A provider's]* **The provider shall apportion its** return on **the** owner's net equity *[shall be apportioned]* to the MO HealthNet program *[on the basis of]* **based on** the provider's MO HealthNet program reimbursable participant resident days of care to total resident days of care during the cost-reporting period. For the purpose of this calculation, total resident days of care shall be the greater of ninety percent (90%) of the provider's certified bed capacity or actual occupancy during the cost year.

(T) Intermediate Care Facility for Individuals with Intellectual Disabilities Federal Reimbursement Allowance (ICF/IID FRA). The fee assessed to ICF/IIDs in the state of Missouri for the privilege of doing business in the state will be an allowable cost.

*[(8)]***(7)** Reporting Requirements.

(A) Annual Cost Report.

1. Each provider shall establish a twelve- (12-) month fiscal period which is to be designated as the provider's fiscal year. *[An]* **The provider shall submit an** annual cost report for the fiscal year *[shall be submitted by the provider]* to the department on forms to be furnished **by the department** for that purpose. *[The]* **Each provider shall submit the** completed cost report *[shall be submitted by each provider]* **by** the first day of the sixth month following the close of the fiscal period.

2. Unless **the provider has previously filed** adequate and current documentation in the following areas *[has been filed previously]* with the department, authenticated copies of the following documents must be submitted **by the provider** with the cost reports: authenticated copies of all leases related to the activities of the facility; all management contracts, all contracts with consultants; federal and state income tax returns for the fiscal year; and documentation of expenditures, by line item, made under all restricted and unrestricted grants. For restricted grants, a statement verifying the restriction as specified by the donor.

3. *[Adequate]* **The facility shall maintain adequate** documentation for all line items on the uniform cost reports *[must be maintained by the facility]* and must *[be submitted]* **submit the document** to the department upon request.

4. If a cost report is more than ten (10) days past due, payment *[shall]* **may** be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this regulation, **the department will release** the **withheld** payments *[that were withheld will be released]* to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's MO HealthNet participation agreement and if terminated, retain all payments which have been withheld pursuant to this provision.

5. If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division *[will]* **may** withhold all remaining payments from the selling provider until **the provider files** the cost report *[is filed]*. The fully completed cost report with all required attachments and documentation is due the first day of the sixth month after the date of change of control, ownership, or termination. Upon receipt of a cost report prepared in accordance with this regulation, **the department will release** any **withheld** payment *[that was withheld will be released]* to the selling provider.

(B) Certification of Cost Reports.

1. The **facility must certify the** accuracy and validity of any cost report *[must be certified]*. Certification must be made by one (1) of the following persons (who must be authorized by the governing body of the facility to make the certification and will furnish proof of the authorization): an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner; or for a public facility, the chief administrative officer of the facility. The cost report must also be notarized by a licensed notary public.

2. Certification statement.

Form of Certification

Misrepresentation or falsifications of any information contained in this report may be punishable by fine, imprisonment, or both, under state or federal law.

Certification by officer or administrator of provider:

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by _____

_____

(Provider's name(s) and number(s))

for the cost report period beginning,

_____, 20_____ and ending _____, 20_____, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

_____ _____ _____

(Signature) *(Title)* *(Date)*

(C) Adequacy of Records.

1. The provider must make available to the department or its duly authorized agent, including federal agents from Health and Human Services (HHS), at all reasonable times, the records as are necessary to permit review and audit of provider's cost reports. Failure to do so may lead to sanctions *[stated in section (8) of this rule or other sanctions]* available in section *[(9)]***(8)** of this rule.

2. *[All]* **The provider shall retain all** records associated with the preparation and documentation of the data associated with the cost report *[must be retained]* for seven (7) years from the cost report filing date.

(D) Accounting Basis.

1. The **provider shall base the submitted** cost report *[submitted must be based]* on the accrual basis of accounting.

2. Governmental institutions that operate on a cash or modified cash basis of accounting may continue to use those methods, provided *[appropriate treatment of capital expenditures is made]* **the governmental institution treats capital expenditures appropriately**.

(E) Audits.

1. *[Cost reports shall be based]* **The provider shall base cost reports** upon the provider's financial and statistical records *[which]* **that** must be capable of verification by audit.

2. If the provider has included the cost of a certified audit of the facility as an allowable cost item to the plan, a copy of that audit report and accompanying letter shall be submitted without deletions.

3. The annual cost report for the fiscal year of the provider may be subject to audit by the Department of Social Services or its contracted agents. Twelve- (12-) month cost reports for new construction facilities required to be submitted under section (4) of this rule may be audited by the department or its contracted agents prior to establishment of a permanent rate.

4. The department **or authorized agent** will conduct a desk review of all cost reports after submission by the provider and shall provide for on-site audits of facilities wherever **their personnel notes a** cost variance or exception *[are noted by their personnel]*.

5. The department shall retain the annual cost report and any working papers relating to the audits of those cost reports for a period of not less than seven (7) full years from the date of submission of the report or completion of the audit.

6. Those providers having an annual Title XIX bed-day ratio on total bed days or certified beds of greater than sixty percent (60%) or an annual Title XIX payment of two hundred thousand dollars ($200,000) or more, or both, shall be required, for at least the first two (2) fiscal years of participation in the plan, to have an annual audit of their financial records by an independent certified public accountant. The auditor may issue a qualified audit report stating that confirmations of accounts receivable and accounts payable are not required by the plan. For the purposes of the paragraph, the Department of Social Services will *[only]* accept *[an]* unqualified opinion**s only if they are** from a certified public accounting firm. A copy of the audit report must be submitted to the department to support the annual cost report of the facility.

*[(9)]***(8)** Sanctions and Overpayments.

(A) *[Sanctions may be imposed]* **The department may impose sanctions** against a provider in accordance with 13 CSR 70-3.030 and other federal or state statutes and regulations.

(B) In the case of overpayments to providers based on, but not limited to, field or audit findings or determinations based on a comprehensive operational review of the facility, the provider shall repay the overpayment in accordance with the provisions as set forth in 13 CSR 70-3.030.

*[(10)]***(9)** Exceptions.

(A) For those MO HealthNet-eligible participant-patients who have concurrent Medicare Part A skilled nursing facilities benefits available, MO HealthNet reimbursement for covered days of stay in a qualified facility will be based on the coinsurance as may be imposed under the Medicare Program.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided **prior authorized** services of fewer than one thousand (1,000) patient days for Missouri Title XIX participants, the reimbursement rate shall be the rate paid for comparable services and level-of-care by the state in which the provider is located; and

2. For providers *[which]* **that** provide **prior authorized** services of one thousand (1,000) or more patient days for Missouri Title XIX participants, the reimbursement rate shall be the lower of—

A. The rate paid for comparable services and level-of-care by the state in which the provider is located; or

B. The rate calculated in *[sections (4) and (6)]* **section (4)** of this rule.

*[(11)]***(10)** Payment Assurance.

(A) The state will pay each provider, which furnished the services in accordance with the requirements of the state plan, the amount determined for services furnished by the provider according to the standards and methods set forth in these rules.

(B) Where third-party payment is involved, MO HealthNet will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Service. Procedures for remitting third-party payments are provided in the MO HealthNet program provider manuals.

*[(12)]***(11)** Provider Participation. Payments made in accordance with the standards and methods described in this rule are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive medical care and services included in the state plan at least to the extent these services are available to the general public.

*[(13)]***(12)** Payment in Full. Participation in the program shall be limited to providers who accept as payment in full for covered services rendered to MO HealthNet participants, the amount paid in accordance with these rules and applicable copayments.

*[(14)]***(13)** Plan Evaluation. *[Documentation will be maintained]* **The provider will maintain documentation** to effectively monitor and evaluate experience during administration of this rule.

*AUTHORITY: sections 208.153, 208.159, [and] 208.201, **and 660.017,** RSMo 2016. This rule was previously filed as 13 CSR 40-81.083. Original rule filed Aug. 13, 1982, effective Nov. 11, 1982. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 25, 2019, effective Nov. 8, 2019, expires May 5, 2020. Amended: Filed Oct. 25, 2019.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately four hundred ten thousand dollars ($410,000) for SFY 2019 and eight hundred twenty thousand dollars ($820,000) annually thereafter.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. **Department Title:** Title 13 - Department of Social Services
Division Title: Division 70 – MO HealthNet Division
Chapter Title: Chapter 10 - Nursing Home Program

Rule Number and Name:	13 CSR 70-10.030 Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/IID Services
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Mental Health	SFY 2019 Cost – approximately $410,000 Annual Fiscal Year Cost – approximately $820,000

III. WORKSHEET

The annual cost of the rate rebase is approximately $820,000 ($285,000 general revenue and $535,000 federal funds). The rate rebase is scheduled to begin January 1, 2019; thus, the SFY 2019 cost is approximately $410,000 ($143,000 general revenue and $267,000 federal funds).

Nonstate Operated ICF/IIDs	Estimated Days	Est. Rate Increase/ Hold Harmless *	Estimated Impact
Facility 1	3,172	$ 33.51	$ 106,294
Facility 2	2,671	$ 69.87	$ 186,623
Facility 3	2,342	$ 78.08	$ 182,863
Facility 4	11,429	$ 29.98	$ 342,641
Facility 5	3,283	$ 0.00	$ 0.00
Facility 6	3,285	$ 0.00	$ 0.00
Facility 7	2,652	$ 0.00	$ 0.00
Total	28,834		$ 818,421

* Facilities that are "Hold Harmless" will not receive a rate increase but will continue to receive their current rate. See IV. Assumptions below for additional information.

IV. ASSUMPTIONS

The rebased rates are based on 2017 cost report data trended to 2019, the year that the rates become effective. A facility whose preliminary, recalculated rate is less than its current rate will continue to receive its current rate (i.e., Hold Harmless).

The estimated days are from the 2017 data. Since the nonstate-operated ICF/IIDs have a stable census from year to year the days from the 2017 base year do not require a utilization adjustment.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

PROPOSED RESCISSION

13 CSR 70-15.090 Procedures for Evaluation of Appropriate Inpatient Hospital Admissions and Continued Days of Stay. This rule established the basis on which hospitals furnishing inpatient care to Medicaid recipients were audited to determine that admissions/lengths of stay were medically necessary, of appropriate duration and setting, and in compliance with Medicaid rules and policies.

PURPOSE: This rule is being rescinded as the MO HealthNet Division (MHD) no longer needs or utilizes this regulation.

AUTHORITY: sections 208.153 and 208.201, RSMo 2016. This rule was previously filed as 13 CSR 40-81.162. Original rule filed May 3, 1985, effective Sept. 1, 1985. For intervening history, please consult the ***Code of State Regulations****. Rescinded: Filed Oct. 25, 2019.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 20—Missouri Local Government Employees' Retirement System (LAGERS)
Chapter 2—Administrative Rules

PROPOSED AMENDMENT

16 CSR 20-2.010 Definitions. The Retirement System amending section (1) by adding definitions of three new terms as a result of the adoption of section 70.631, RSMo and amending the purpose to include section 70.631, RSMo.

PURPOSE: The proposed amendment defines the terms "emergency medical service personnel," "emergency telecommunicator," and "jailor" as those terms are used in section 70.631, RSMo.

PURPOSE: The purpose of this rule is to expand on ***and clarify*** *definitions* ***of terms*** *found in sections 70.600* ***and 70.631****, RSMo [(1986)].*

(1) Employee.

(E) The term "emergency medical service personnel" means any regular or permanent employee of a political subdivision possessing the duty and power to provide Advanced Life Support or Basic Life Support treatment, and who is required to be certified by the Missouri Bureau of Emergency Medical Services as an Emergency Medical Technician Basic (EMT-B), Advanced Emergency Medical Technician (AEMT) or an Emergency Medical Technician-Paramedic (EMT-P), or whose duties include direct supervision of EMT-B, AEMT and/or EMT-P personnel.

1. The term "emergency medical service personnel" shall not include volunteer EMT-Bs, AEMTs or EMT-Ps or any person temporarily employed as an EMT-B, AEMT or EMT-P for an emergency.

(F) The term "emergency telecommunicator" means any regular or permanent employee of a political subdivision employed as an emergency telephone or telecommunications worker, call taker, or public safety dispatcher whose duties include receiving, processing, or transmitting public safety information received through a Public Safety Answering Point, or whose duties include direct supervision of emergency telecommunicator personnel.

1. The term "emergency telecommunicator" shall not include any volunteer emergency telecommunicators or any person temporarily employed as an emergency telecommunicator for an emergency.

(G) The term "jailor" means any regular or permanent employee of a political subdivision employed for the duty of monitoring, transporting, or detaining inmates or other detainees held in the jail or other correctional facility of the political subdivision or whose duties include direct supervision of jailor personnel.

1. The term "jailor" shall not include any volunteer jailors or any person temporarily employed as jailor for an emergency.

AUTHORITY: section 70.605.21, RSMo [Supp. 2007] ***2016****. Original rule filed Dec. 29,1975, effective Jan. 8, 1976. Amended: Filed Feb. 16, 1999, effective July 30, 1999. Amended: Filed Feb. 28, 2008, effective Aug. 30, 2008. Amended: Filed Oct. 28, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Any interested person or entity may submit written comments in support of or in opposition to the proposed amendment. Comments should be directed to the Missouri Local Government Employees Retirement System (LAGERS), Attn: Jason A. Paulsmeyer, Chief Counsel, PO Box 1665, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 20—Division of Community and Public Health
Chapter 2—Protection of Drugs and Cosmetics

PROPOSED RESCISSION

19 CSR 20-2.020 Inspection of the Manufacture and Sale of Cosmetics. This rule established manufacturing and labeling standards for cosmetics as these products relate to public health.

PURPOSE: This rule is being rescinded as it is outdated and no longer necessary.

AUTHORITY: section 196.045, RSMo 1986. This rule previously filed as 13 CSR 50-72.010. Original rule entitled Missouri Division of Health E 1.20 was filed on Nov. 17, 1949, effective Nov. 27, 1949. Rescinded: Filed Oct. 18, 2019.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the

aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with PO Box 570, Jefferson City, MO 651002-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 20—Division of Community and Public Health
Chapter 3—General Sanitation

PROPOSED RESCISSION

19 CSR 20-3.040 Environmental Health Standards for the Control of Communicable Diseases. This rule provided general sanitation rules which helped assure conditions were not injurious to the health of the people.

PURPOSE: This rule is being rescinded as it is outdated and no longer necessary.

AUTHORITY: section 192.020, RSMo 1986. This rule previously filed as 13 CSR 50-83.010. Original rule filed May 12, 1949, effective May 22, 1949. Rescinded: Filed Oct. 18, 2019.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with PO Box 570, Jefferson City, MO 651002-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 40—Division of Maternal, Child and Family Health
Chapter 4—Early Periodic Screening, Diagnosis and Treatment (EPSDT)

PROPOSED RESCISSION

19 CSR 40-4.010 Basis for Provisions of EPSDT. This rule established basis and criteria for provision of EPSDT services.

PURPOSE: This rule is being rescinded as the EPSDT program resides with Department of Social Services and DSS has promulgated rules for provision of services through EPSDT as 13 CSR 40-37.010. Therefore, this rule is unnecessary.

AUTHORITY: sections 191.420 and 192.020, RSMo 1986. This rule was previously filed as 13 CSR 50-157.010. Original rule filed Dec. 30, 1975, effective Jan. 9, 1976. Amended: Filed May 10, 1978, effective Aug. 11, 1978. Emergency amendment filed Aug. 16, 1979, effective Oct. 1, 1979, expried Nov. 10, 1979. Amended: Filed Aug. 16, 1979, effective Nov. 11, 1979. Amended: Filed Jan. 15, 1985, effetive April 11, 1985. Rescinded: Filed Oct. 18, 2019.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with PO Box 570, Jefferson City, MO 651002-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 40—Division of Maternal, Child and Family Health
Chapter 7—Metabolic Formula Program

PROPOSED RESCISSION

19 CSR 40-7.010 Definitions. This rule defined the terms used in this chapter.

PURPOSE: This rule is being rescinded as the rule has expired and 19 CSR 40-7.040 now defines the terms used in this chapter.

AUTHORITY: sections 191.300-191.380, RSMo (1994 and Supp. 1995). Emergency rule filed Aug. 19, 1996, effective Aug. 29, 1996, expired Feb. 24, 1997. Original rule filed Aug. 15, 1996, effective Jan. 30, 1997. Rescinded: Filed Oct. 18, 2019.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 40—Division of Maternal, Child and Family Health
Chapter 7—Metabolic Formula Program

PROPOSED RESCISSION

19 CSR 40-7.020 Program Eligibility. The Department of Health (DOH) provided low-protein formula, a special dietary product, to individuals diagnosed as having phenylketonuria (PKU), maple syrup urine disease (MSUD) and other metabolic conditions as approved by the Newborn Screening Standing Committee. This rule establishes the criteria by which the Formula Distribution Program accepts clients for service.

PURPOSE: This rule is being rescinded as the rule has expired and 19 CSR 40-7.050 establishes the criteria for acceptance of clients for service by the Metabolic Formula Program.

AUTHORITY: sections 191.300-191.380, RSMo (1994 and Supp. 1995). Original rule filed Aug. 15, 1996, effective Jan. 30, 1997. Rescinded: Filed Oct. 18, 2019.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 40—Division of Maternal, Child and Family Health
Chapter 7—Metabolic Formula Program

PROPOSED RESCISSION

19 CSR 40-7.030 Client Responsibilities. This rule established how clients maintain program eligibility.

PURPOSE: This rule is being rescinded as the rule has expired and 19 CSR 40-7.050 and 19 CSR 40-7.060 addresses eligibility and the process for participation in the Metabolic Formula Program.

AUTHORITY: sections 191.300-191.380, RSMo (1994 and Supp. 1995). Emergency rule filed Aug. 19, 1996, effective Aug. 29, 1996, expired Feb. 24, 1997. Original rule filed Aug. 15, 1996, effective Jan. 30, 1997. Rescinded: Filed Oct. 18, 2019.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2040—Office of Athletics
Chapter 4—Licensees and Their Responsibilities

PROPOSED AMENDMENT

20 CSR 2040-4.015 Promoters. The office is adding section (14).

PURPOSE: This amendment adds language regarding access to national databases.

(14) A promoter of an event for professional boxing, professional and amateur kickboxing, professional full-contact karate, professional and amateur mixed martial arts events, are responsible to register their event with the certified registry as approved by the Association of Boxing Commissions for their respective sport. The promoter of an event is responsible for all fees associated with registering their event with the respective database. No bouts will be approved until such time that a promoter provides proof that the proposed event is registered with the respective database.

*AUTHORITY: section 317.006, RSMo Supp. [2018] **2019**, and section 317.015, RSMo 2016. This rule originally filed as 4 CSR 40-4.015. Original rule filed April 30, 1982, effective Sept. 11, 1982. Rescinded and readopted: Filed March 2, 1989, effective May 11, 1989. Rescinded and readopted: Filed Nov. 15, 2001, effective May 30, 2002. Moved to 20 CSR 2040-4.015, effective Aug. 28, 2006. Amended: Filed March 20, 2018, effective Sept. 30, 2018. Amended: Filed Jan. 25, 2019, effective Aug. 30, 2019. Amended: Filed Oct. 25, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities six thousand six hundred dollars ($6,600) annually thereafter for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of Athletics, PO Box 1335, Jefferson City, MO 65102, by facsimile at 573-751-5649, or via email at athletic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

PRIVATE FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Commerce and Insurance
Division 2040 - Office of Athletics
Chapter 4 - Licensees and Their Responsibilities
Proposed Amendment - 20 CSR 2040-4.015 Promoters

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the amendment by affected entities:
44	Promoters (Per Event Fee @ 150)	$6,600
	Estimated Annual Cost of Compliance for the Life of the Rule	**$6,600**

III. WORKSHEET

See Table Above

IV. ASSUMPTION

1. The figures reported above are based on calendar year 2018 actuals.
2. During calendar year 2018, the office regulated 44 events which would be subject to this new rule. The office averaged the cost to the promoter for an event to be $150 per event. Some events will be much less since most boxing events average about 6 to 8 bouts which will range in cost from $90 to $120 per event. Most martial arts events average between 8 and 15 bouts which will range in cost from $120 to $195 the cap amount.
3. It is anticipated that the total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2233—State Committee of Marital and Family Therapists
Chapter 1—General Rules

PROPOSED AMENDMENT

20 CSR 2233-1.040 Fees. The committee is adding section (3).

PURPOSE: This amendment allows the change of supervision fee to be waived under certain criteria.

(3) A change of supervision fee shall not be required for supervised experience in marital and family therapy upon request by the applicant, accompanied by a letter from the graduate program documenting the following:

(A) Licensure supervision is part of a doctoral or specialist degree or thirty (30) hours of post master's degree course work in marital and family therapy or a mental health discipline as defined in 20 CSR 2233-2.010;

(B) Licensure supervisor is a faculty member of the educational institution in which the applicant is currently enrolled; and

(C) Licensure supervisor is not reimbursed by the applicant for licensure supervision.

AUTHORITY: sections 337.712 and 337.727, RSMo Supp.2019. This rule originally filed as 4 CSR 233-1.040. Original rule filed Dec. 31, 1997, effective July 30, 1998. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed Oct. 25, 2019.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions one hundred twenty-five dollars ($125) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will save private entities agencies one hundred twenty-five dollars ($125) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with State Committee of Marital and Family Therapists, Gloria Lindsey, Executive Director, PO Box 1335, Jefferson City, MO 65102, by faxing comments to (573) 751-0735, or by emailing comments to maritalfam@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC FISCAL NOTE

I. RULE NUMBER

Title 20 -Department of Commerce and Insurance
Division 2233 - State Committee of Marital and Family Therapists
Chapter 1 - General Rules
Proposed Amendment to 20 CSR 2233-1.040 - Fees

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Loss of Revenue	
State Committee of Marital and Family Therapists		$125
	Total Loss of Revenue Annually for the Life of the Rule	**$125**

III. WORKSHEET

See Private Entity Fiscal Note.

IV. ASSUMPTION

1. The total loss of revenue is based on the cost savings to private entities reflected in the Private Fiscal Note filed with this rule.

PRIVATE FISCAL NOTE

I. RULE NUMBER

Title 20 -Department of Insurance, Financial Institutions and Professional
Division 2233 - State Committee of Marital and Family Therapists
Chapter 1 - General Rules
Proposed Amendment to 20 CSR 2233-1.040 - Fees

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated savings for the life of the rule by affected entities:
5	Change of Supervision Fee (Fee Cost Savings @ $25)	$125
	Estimated Annual Savings for the Life of the Rule	**$125**

III. WORKSHEET

See Table Above.

IV. ASSUMPTION

1. The board anticipates 5 supervisees will request the fee waiver to change supervisors.
2. It is anticipated that the total fiscal savings will occur beginning in FY2020, may vary with inflation, and is expected to increase at the rate projected by the Legislative Oversight Committee.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (3), (5), and (13).

PURPOSE: This amendment revises plan change criteria for Medicare Advantage Plan members, default enrollment procedures, clarifies disabled dependent eligibility, reporting of other health coverage, and renumbers as necessary.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov or through another designated enrollment system within thirty-one (31) days of his/her hire date or the date the employer notifies the employee that s/he is an eligible variable-hour employee. If enrolling a spouse or child(ren), proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect, change, or cancel coverage for the next plan year during the annual open enrollment period that runs October 1 through October 31 of each year.

3. An active employee may elect or change coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. An employee or his/her spouse/child(ren) may enroll within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a child, the active employee may enroll the child in an MCHCP plan within sixty (60) days of the court order.

4. Default enrollment.

A. If an active employee is enrolled in the PPO *[300 or]* **750,** PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled **in the same plan enrolled in the prior year** at the same level of coverage *[in the PPO 1250 Plan provided through the vendor the employee is enrolled in, effective the first day of the next calendar year]*.

[B. If an active employee is enrolled in the Health Savings Account (HSA) Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the HSA Plan at the same level of coverage.]

*[C.]***B.** If an active employee is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

*[D.]***C.** Married state employees who are both MCHCP members who do not complete enrollment during the open enrollment period, will continue to meet one (1) family deductible and out-of-pocket maximum if they chose to do so during the previous plan year.

*[E.]***D.** If an active employee is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents or spouse/child(ren) at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date even if the retiree is continuing coverage as a variable-hour employee after retirement. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment, but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical,

dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. A retiree enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

*[5.]***6.** Default enrollment.

A. A retiree with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the retiree or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the retiree *[does not have Medicare Part B, and does not complete enrollment during the open enrollment period,]* **is not able to be enrolled in the Medicare Advantage Plan,** the retiree and his/her dependents without Medicare will be enrolled in the *[PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]* **same plan enrolled in the prior year at the same level of coverage.**

B. If a retiree with Medicare *[is]* **has a non-Medicare dependent** enrolled in the PPO *[300]* **750**, *[or]* PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, *[and has dependents who are not covered by Medicare,]* his/her dependents without Medicare will be enrolled in *[the PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* **the same plan enrolled in the prior year with the same level of coverage**.

C. If a retiree without Medicare is enrolled in the PPO *[300]* **750**, *[or]* PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

[D. If a retiree without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the retiree is enrolled in at the same level of coverage, effective the first day of the next calendar year.]

*[E.]***D.** If a retiree without Medicare is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage, effective the first day of the next calendar year.

*[6.]***7.** If a retiree is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

*[7.]***8.** If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. A terminated vested member enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

*[3.]***4.** Default enrollment.

A. A terminated vested subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the terminated vested subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the terminated vested subscriber *[does not have Medicare Part B, and does not complete enrollment during the open enrollment period]* **is not able to be enrolled in the Medicare Advantage Plan**, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

B. If a terminated vested subscriber without Medicare is enrolled in the PPO *[300]* **750,** *[or]* PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

[C. If a terminated vested subscriber without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the terminated vested subscriber is enrolled in effective the first day of the next calendar year, at the same level of coverage.]

*[D.]***C.** If a terminated vested subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

*[E.]***D.** If a terminated vested subscriber is enrolled in dental

and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

*[4.]***5.** If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. A long-term disability member enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

*[3.]***4.** Default enrollment.

A. A long-term disability subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the long-term disability subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the long-term disability subscriber *[does not have Medicare Part B, and does not complete enrollment during the open enrollment period]* **is not able to be enrolled in the Medicare Advantage Plan**, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

B. If a long-term disability subscriber without Medicare is enrolled in the PPO *[300]* **750,** *[or]* PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the long-term disability subscriber is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

C. If a long-term disability subscriber with Medicare *[is]* **has a non-Medicare dependent** enrolled in the PPO *[300]* **750,** *[or]* PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period *[and has dependents who are not covered by Medicare]*, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

[D. If a long-term disability subscriber without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the long-term disability subscriber is enrolled in at the same level of coverage, effective the first day of the next calendar year.]

*[E.]***D.** If a long-term disability subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

*[F.]***E.** If a long-term disability subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

*[4.]***5.** If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

1. A survivor **without Medicare** must submit a survivor enrollment form *[and a copy of the death certificate]* within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor with Medicare will be automatically enrolled as a survivor following the death of the employee.

*[2.]***3.** A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days due to an

involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

*[3.]***4.** A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. A survivor enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

*[4.]***6.** Default enrollment.

A. A survivor with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the survivor or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the survivor *[does not have Medicare Part B, and does not complete enrollment during the open enrollment period]* **is not able to be enrolled in the Medicare Advantage Plan**, the survivor and his/her dependents without Medicare will be enrolled in the *[PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

B. If a survivor without Medicare is enrolled in the PPO *[300]* **750,** *[or]* PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the survivor is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

C. If a survivor with Medicare has a non-Medicare dependent *[is]* enrolled in the PPO *[300]* **750,** *[or]* PPO *[600]* **1250**, **or HSA** Plan and does not complete enrollment during the open enrollment period *[and has dependents who are not covered by Medicare]*, the survivor and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* **same plan enrolled in the prior year with the same level of coverage**.

[D. If a survivor without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the survivor is enrolled in at the same level of coverage, effective the first day of the next calendar year.]

*[E.]***D.** If a survivor without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

*[F.]***E.** If a survivor is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

*[5.]***7.** If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(G) Disabled Dependent.

1. A**n** *[new]* employee may enroll his/her permanently disabled child **when first eligible** or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the end of the month of the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of *[a new employee and his/her]* **the** permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or will never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(13) Members are required to disclose to the claims administrator whether or not they have other health coverage and, if so, information about the coverage. *[A member may submit this information to the claims administrator by phone, fax, mail, or online. Dependent claims will be denied if the disclosure is not made.]* Once the information is received, claims will be reprocessed subject to all applicable rules.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500)

in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RESCISSION

22 CSR 10-2.045 Plan Utilization Review Policy. This rule established the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded reflect changes due to a new third party administrator.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Rescinded: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan Medical Plans.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization—The claims administrator must authorize some services in advance. Preauthorization is to determine if the procedure or treatment is medically necessary. The claims administrator will determine what procedures or treatments are subject to preauthorization. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, or who are enrolled in the Medicare Advantage Plan are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. A list of medical services for which preauthorization is required may be obtained at any time from the claims administrator.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization requests will be made within thirty-six (36) hours, which will include one (1) business day of the receipt of the request. If the information necessary to make a benefit determination is not received, the claims administrator will notify the member and provider of any necessary extension. The provider will be given forty-five (45) calendar days from receipt of the extension notice to respond with additional information. Once the information is received or the forty-five (45) days have elapsed, a determination will be made within thirty-six (36) hours which will include one (1) business day.

B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than one (1) business day of the receipt of all necessary information;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision;

(C) Retrospective Review—Reviews to determine coverage after services have been provided to a member. The retrospective review is not limited to an evaluation of medical necessity, reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment. The claim administrator shall have the authority to correct payment errors when identified under retrospective review;

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment; and

(E) Case Management—A voluntary process to assess, coordinate, and evaluate options and services of members with catastrophic and complex illnesses. A case manager will help members understand what to expect during the course of treatment, help establish collaborative goals, complete assessments to determine needs, interface

with providers, and negotiate care. Members are identified for case management through claim information, length of hospital stay, or by referral. The case manager will dismiss the member from case management once the case manager determines that objectives have been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Rescinded and readopted: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (5), (11), (12), and (14).

PURPOSE: This amendment adds one hundred percent (100%) coverage for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, and services performed in another country for the PPO 750 Plan.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; *[and]*

(D) Four (4) Diabetes Self-Management Education visits*[.]***; and**

(E) Sterilization procedure for men.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claim administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service, **unless otherwise specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.047 PPO 1250 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (5), (11), (12), and (14).

PURPOSE: This amendment adds one hundred percent (100%) coverage for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, and services performed in another country for the PPO 1250 Plan.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; *[and]*

(D) Four (4) Diabetes Self-Management Education visits*[.]***; and**

(E) Sterilization procedure for men.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claim administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months

following the date of service**, unless otherwise specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 30, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
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PROPOSED AMENDMENT

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (3), (14), (15), (17), adding section (9), and renumbering as necessary.

PURPOSE: This amendment revises the Health Savings Account (HSA) Plan individual family member out-of-pocket maximum, adds one hundred percent (100%) coverage after deductible is met for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, services performed in another country, and renumbers as necessary.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—four thousand nine hundred fifty dollars ($4,950);

2. Network out-of-pocket maximum for family—nine thousand nine hundred dollars ($9,900). Any individual family member need only incur a maximum of *[seven thousand nine hundred dollars ($7,900)]* **eight thousand one hundred fifty dollars ($8,150)** before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual—nine thousand nine hundred dollars ($9,900); and

4. Non-network out-of-pocket maximum for family—nineteen thousand eight hundred dollars ($19,800).

(9) Sterilization procedure for men is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

*[(9)]***(10)** Newborn's claims will be subject to deductible and coinsurance.

*[(10)]***(11)** Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

*[(11)]***(12)** Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

*[(12)]***(13)** Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

*[(13)]***(14)** Maximum plan payment—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claims administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

*[(14)]***(15)** Any claim must be initially submitted within twelve (12) months following the date of service**, unless otherwise specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

*[(15)]***(16)** For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

*[(16)]***(17)** Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

*[(17)]***(18)** An active employee subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section *[(19)]* **(20)** of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare (unless Medicare is secondary coverage to MCHCP);

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-purpose health FSA, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

*[(18)]***(19)** If an active employee subscriber and/or his/her dependent(s) is enrolled in the HSA Plan and becomes ineligible for the HSA Plan during the plan year, the subscriber and/or his/her dependent(s) will be enrolled in the PPO 1250 Plan. The subscriber may enroll in a different non-HSA Plan within thirty-one (31) days of notice from MCHCP.

*[(19)]***(20)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

*[(20)]***(21)** Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the subscriber must be an active employee and HSA eligible as defined in the Internal Revenue Service Publication 969 on the date the contribution is made and open an HSA with the bank designated by MCHCP.

1. Subscribers who enroll in the HSA Plan during open enrollment who have a balance in a health care FSA on January 1 of the new plan year cannot receive an HSA contribution from MCHCP until after the health care FSA grace period ends March 15.

(B) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP contribution will receive an applicable prorated contribution. Unless a subscriber is eligible for a special enrollment period, a subscriber will not be able to voluntarily change his/her plan selection.

(C) A subscriber who moves from subscriber-only coverage to another coverage level with an effective date after the MCHCP contribution will receive an applicable prorated contribution based on the increased level of coverage.

(D) If a subscriber moves from another coverage level to subscriber-only coverage, cancels all coverage, or MCHCP terminates coverage and has received an HSA contribution, MCHCP will not request a re-payment of the contribution.

(E) If both spouses are state employees covered by MCHCP and they both enroll in an HSA Plan, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars ($600) regardless of the number of HSAs or the number of children covered under the HSA Plan for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a maximum three hundred dollar ($300) contribution to each spouse to total **a** maximum **of** six hundred dollars ($600).

(F) The MCHCP contributions will be deposited into the subscriber's HSA as follows:

1. The January deposit will be made on the third Monday of the month, or the first working day after the third Monday if the third Monday is a holiday;

2. The April deposit will be made on the first Monday in April; and

3. Other deposits will be made on the first Monday of the month in which coverage is effective, or the first working day after the first Monday of the month coverage is effective if the first Monday is a state holiday.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

PURPOSE: This amendment revises the medical plan benefits for transition of care, allergy testing and immunotherapy, bariatric surgery, bone growth stimulators, cardiac rehabilitation, chelation therapy, chiropractic services, cochlear implant, dental care, emergency room services, genetic counseling, hearing aids, hospice care and palliative services, hospital, injections, maternity coverage, nutrition therapy, orthognathic or jaw surgery, orthotics, and renumbers as necessary.

[(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits

with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. Benefits eligible for transition of care include:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;

(C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;

(D) Home nursing care;

(E) Radiation therapy;

(F) Dialysis;

(G) Durable medical equipment;

(H) Cancer treatment;

(I) Clinical trials;

(J) Physical, speech, or occupational therapy;

(K) Hospice care;

(L) Bariatric surgery, and follow-up per criteria covered under the plan;

(M) Inpatient hospitalization at the time of the network change;

(N) Mental health services; or

(O) Related follow-up services within three (3) months of an acute injury or surgery.]

(2) Transition of Care. A transition of care option is available for members who seek to continue to remain under the care of an non-network provider who was treating them prior to the provider losing network status. A subscriber and his/her dependents may request to continue receiving care at the network benefit level. If approved, the member will be eligible to continue care with the current non-network provider at the network benefit level for a period of time until it is medically appropriate for the member to transfer care to a network provider. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. The following benefits are eligible for transition of care as determined by the claims administrator:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their third trimester of pregnancy;

(C) Radiation therapy;

(D) Dialysis;

(E) Cancer treatment;

(F) Physical, speech, or occupational therapy;

(G) Hospice care;

(H) Inpatient hospitalization at the time of the network change; or

(I) Mental health services.

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250, and HSA Plan.

[(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.]

*[(E)]***(D)** Plan benefits for the PPO 750 Plan, PPO 1250, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms*[. The following tests and treatments are covered:]***;**

[A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or

(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or

(II) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;]

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism;

4. Bariatric surgery*[. Bariatric surgery is covered when all of the following requirements have been met:]***;**

[A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;]

5. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

6. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit*[. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:]*;

[A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;]

7. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

8. Cardiac rehabilitation*[. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:]*;

[A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;]

9. Chelation therapy*[. The administration of FDA-approved chelating agents is covered for any of the following conditions:]*;

[A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;]

10. Chiropractic services*[. Chiropractic]*—manipulation and adjunct therapeutic procedures/modalities *[(e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:]*;

[A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed homecare program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);]

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial.

Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant *[device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:]* **and auditory brainstem implant;**

[A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;]

13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. Treatment must be initiated within sixty (60) days of accident; and

(II) Restorative services limited to dental implants when needed as a result of *[cancerous or non-cancerous]* tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical

center;

14. Diabetes Self-Management Education;

15. Dialysis is covered when received through a network provider;

16. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

17. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit*[. Hospital and ancillary charges are paid as a network benefit]*;

18. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement within one (1) year following cataract surgery;

19. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

20. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing*[.]***;**

[A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azoopermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;]

21. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

22. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

23. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

24. Hearing aids (per ear). Hearing aids covered **once every two (2) years** for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

[A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years.] If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

*[(I)]***A.** Conventional: one thousand dollars ($1,000).

*[(II)]***B.** Programmable: two thousand dollars ($2,000).

*[(III)]***C.** Digital: two thousand five hundred dollars ($2,500).

*[(IV)]***D.** Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

25. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

26. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

27. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill *[and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.]***;**

[A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;]

28. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services *[are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:]***; and**

[(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and]

(V) Outpatient mental health services *[are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:]***;**

[(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;]

29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

30. Injections. See preventive services for coverage of vaccinations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit*[.]***;**

[A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;
(II) Crohn's disease;
(III) Ulcerative colitis;
(IV) Inflammatory bowel disease;
(V) Intestinal malabsorption;
(VI) Fish tapeworm anemia;
(VII) Vitamin B12 deficiency;
(VIII) Other vitamin B12 deficiency anemia;
(IX) Macrocytic anemia;
(X) Other specified megaloblastic anemias;
(XI) Megaloblastic anemia;
(XII) Malnutrition of alcoholism;
(XIII) Thrombocytopenia, unspecified;
(XIV) Dementia in conditions classified elsewhere;
(XV) Polyneuropathy in diseases classified elsewhere;
(XVI) Alcoholic polyneuropathy;
(XVII) Regional enteritis of small intestine;
(XVIII) Postgastric surgery syndromes;
(XIX) Other prophylactic chemo-therapy;
(XX) Intestinal bypass or anastomosis status;
(XXI) Acquired absence of stomach;
(XXII) Pancreatic insufficiency; and
(XXIII) Ideopathic progressive polyneuropathy;]

31. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

32. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to *[the]* **applicable copayments,** deductible**,** and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

33. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

34. Nutrition therapy*[.]***;**

[A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;]

35. Office visit. Member encounter with a provider for health care, mental health, or substance use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

36. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

37. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. *[Cancerous or non-cancerous t]***T**umors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical *[or physiological]* abnormality *[when one (1) of the following criteria is met:]***;**

[(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibularfossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;]

38. Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with agoniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is

an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered *[for members who meet the following criteria:]***.**

[(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.]

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

39. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. Online weight management program offered through the plan's exclusive provider arrangement;

40. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal

wear and tear, if there is a change in medical condition, or if growth-related;

41. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

42. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

43. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

44. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

45. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

46. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

47. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations.*** *Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.061 Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment revises the following benefits not payable by the plan: alternative therapies, assistant surgeon services, birthing center, home births, nocturnal enuresis alarm, therapy, vaccinations requested by a third party, and renumbers as necessary.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-2.055 or 22 CSR 10-2.090.

(C) Alternative therapies—that are outside conventional medicine *[including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback]* **as determined by the claims administrator**.

[(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.]

*[(F)]***(E)** Athletic enhancement services and sports performance training.

*[(G)]***(F)** Autopsy.

[(H) Birthing center.]

*[(I)]***(G)** Blood donor expenses.

*[(J)]***(H)** Blood pressure cuffs/monitors.

*[(K)]***(I)** Care received without charge.

*[(L)]***(J)** Charges exceeding the vendor contracted rate or benefit limit.

*[(M)]***(K)** Charges resulting from the failure to appropriately cancel a scheduled appointment.

*[(N)]***(L)** Childbirth classes.

*[(O)]***(M)** Comfort and convenience items.

*[(P)]***(N)** Cosmetic procedures.

*[(Q)]***(O)** Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

*[(R)]***(P)** Dental care, including oral surgery.

*[(S)]***(Q)** Devices or supplies bundled as part of a service are not separately covered.

*[(T)]***(R)** Dialysis received through a non-network provider.

*[(U)]***(S)** Educational or psychological testing unless part of a treatment program for covered services.

*[(V)]***(T)** Examinations requested by a third party.

*[(W)]***(U)** Exercise equipment.

*[(X)]***(V)** Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

*[(Y)]***(W)** Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

*[(Z)]***(X)** Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

*[(AA)]***(Y)** Health and athletic club membership—including costs of enrollment.

*[(BB)]***(Z)** Hearing aid replacement batteries.

[(CC) Home births.

*(DD)]***(AA)** Infertility treatment beyond the covered services to diagnose the condition.

*[(EE)]***(BB)** Infusions received through a non-network provider.

*[(FF)]***(CC)** Level of care, greater than is needed for the treatment of the illness or injury.

*[(GG)]***(DD)** Long-term care.

*[(HH)]***(EE)** Maxillofacial surgery.

*[(II)]***(FF)** Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

*[(JJ)]***(GG)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

*[(KK)]***(HH)** Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

*[(LL)]***(II)** Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

[(MM) Nocturnal enuresis alarm.]

*[(NN)]***(JJ)** Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

*[(OO)]***(KK)** Non-medically necessary services.

*[(PP)]***(LL)** Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

*[(QQ)]***(MM)** Non-reusable disposable supplies.

*[(RR)]***(NN)** Online weight management programs.

*[(SS)]***(OO)** Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

*[(TT)]***(PP)** Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, nonsedating antihistamines, unless otherwise covered as a preventive service.

*[(UU)]***(QQ)** Physical and recreational fitness.

*[(VV)]***(RR)** Private-duty nursing.

[(WW)]**(SS)** Routine foot care without the presence of systemic disease that affects lower extremities.

*[(XX)]***(TT)** Services obtained at a government facility if care is provided without charge.

*[(YY)]***(UU)** Sex therapy.

*[(ZZ)]***(VV)** Surrogacy—pregnancy coverage is limited to plan member.

*[(AAA)]***(WW)** Telehealth site origination fees or costs for the provision of telehealth services are not covered.

[(BBB) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program

through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.]

*[(CCC)]***(XX)** Travel expenses.

[(DDD) Vaccinations requested by third party.]

*[(EEE)]***(YY)** Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment revises the order of benefit determination rules and renumbers as necessary.

(3) Order of Benefit Determination Rules.

(B) Rules. MCHCP determines its order of benefits *[using the first of the following rules which applies]* **as follows**:

[1. Active/inactive employee. The benefits of the plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of the plan which covers that person as a laid off or retired employee (or as that employee's dependent);

2. Nondependent/dependent. The benefits of the plan which covers the person as an employer or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent;]

1. Non-Dependent/Dependent:

A. The plan which covers the member as an employee or subscriber is primary; and

B. The plan which covers the member as dependent is secondary;

2. Active/layoff. The plan that covers the member or dependent through the member's active employment is primary to a plan that covers the member or dependent through the member's status as a laid off employee;

3. Retiree. The plan that covers the member or dependent through the member's active employment is primary to a plan that covers the member or dependent through the member's status as a retiree;

*[3.]***4.** Medicare.

A. If a member is an active employee and has Medicare, MCHCP is the primary plan for the active employee and his/her dependents. Medicare is the secondary plan except for members with end stage renal disease (ESRD) as defined in subparagraph (3)(B)*[3.]***4.**D.

B. If a member is a retiree and has Medicare, Medicare is the primary plan for the retiree and his/her Medicare-eligible dependents. MCHCP is the secondary plan.

C. If a terminated vested employee with Medicare maintains coverage through one (1) of the MCHCP plans, Medicare is the primary plan and MCHCP is secondary.

D. If a member or his/her dependents are eligible for Medicare solely because of ESRD, the member's MCHCP plan is primary to Medicare during the first thirty (30) months of Medicare eligibility for home peritoneal dialysis or home hemodialysis and thirty-three (33) months for in-center dialysis. After the thirty (30) or thirty-three (33) months, Medicare becomes primary, and claims

are submitted first to Medicare, then to MCHCP for secondary coverage. The member is responsible for notifying MCHCP of his/her Medicare status.

E. If a member is on long-term disability through the Missouri State Employees' Retirement System or the Public School Retirement System and is eligible for Medicare, Medicare is the primary plan and MCHCP plan is secondary;

*[4.]***5.** Dependent child/parents not separated or divorced. When MCHCP and another plan cover the same child as a dependent of different *[persons, called]* parents—

A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

B. If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time;

*[5.]***6.** Dependent child/separated, divorced, or never married. If two (2) or more plans cover a person as a dependent child of divorced, separated, or never married parents, benefits for the child are determined in this order—

A. First, the plan of the parent with custody of the child;

B. Then, the plan of the spouse of the parent with the custody of the child;

C. Then, the plan of the parent not having custody of the child; and

D. Finally, the plan of the spouse of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;

*[6.]***7.** Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (3)(B)*[4.]***5.**;

*[7.]***8.** Dependent child/parents both parents covered by MCHCP. If both parents are covered by MCHCP and both parents cover the child as a dependent, MCHCP will not coordinate benefits with itself;

*[8.]***9.** *[The plan that covers the member as a spouse is primary over the plan that covers the member as a dependent child]* **When an adult dependent is covered by both spouse and parent, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term**; and

*[9.]***10.** Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term.

AUTHORITY: sections 103.059, [RSMo 2000], and [section] 103.089, RSMo [Supp. 2013] ***2016****. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (1), (3), and (5).

PURPOSE: This amendment revises the claim submission and initial benefit determinations time frames and updates the name and appeal contact information for the third party administrator.

(1) Claims Submissions and Initial Benefit Determinations PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than *[fifteen (15) days]* **twenty (20) business days** from the date the vendor receives the claim. The vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days if, for reasons beyond the vendor's control, the decision cannot be made within the first *[fifteen (15)]* **twenty (20)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)]* **twenty-(20-)** day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15)]* **thirty (30)** days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor *[as soon as possible thereafter]* **within three (3) business days**.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than *[thirty (30) days]* **twenty (20) business days** after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days. The vendor must notify the member

prior to the expiration of the first *[fifteen- (15-) day]* **twenty- (20-) day** period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15) days]* **thirty (30) days** after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously-approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously-approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(3) Appeal Process for Medical and Pharmacy Determinations for PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply:

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage after an individual has been covered under the plan;

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination;

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative;

4. External review. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by *[UMR, Aetna]* **Anthem**, and Express Scripts, Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time);

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law;

6. Final external review decision. A final external review decision means a determination rendered under the external review process at the conclusion of an external review; and

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect; or

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-2.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be *[responded to in writing to the member]* **decided** within *[thirty (30)]* **twenty (20) business** days *[for post-service claims and fifteen (15) days for pre-service claims]* from the date the vendor received the first level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)]* **twenty- (20-)** day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the

information to the vendor. The vendor then must decide the claim no later than *[fifteen (15)]* **thirty (30)** days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first. **Written confirmation of the decision will be sent by the vendor within fifteen (15) business days.**

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) *[working]* **business** days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals *[shall]* **will** be *[responded to in writing to the member]* **decided** within *[thirty (30)]* **twenty (20)** days *[for post-service claims and within fifteen (15) days for pre-service claims]* from the date the vendor received the second level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)]* **twenty- (20-)** day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15)]* **thirty (30)** days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first. **Written confirmation of the decision will be sent by the vendor within fifteen (15) business days.**

(V) For members with medical coverage through *[UMR]* **Anthem**—

(a) First and second level pre-service**, first and second level post-service,** and concurrent claim appeals must be submitted in writing to—

[UMR Appeals
PO Box 400046
San Antonio, TX 78229
or by fax to (888) 615-6584]
Anthem Blue Cross and Blue Shield
Attn: Grievance Department
PO Box 105568
Atlanta, Georgia 30348-5568
or by fax to (800) 859-3046

[(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546
or by fax to (877) 291-3248]

*[(c)]***(b)** Expedited *[pre-service]* appeals *[must]* **may** be *[communicated]* **submitted** by calling *[(800) 808-4424, ext. 15227]* **(877) 333-7488** or by submitting a written fax to *[(888) 615-6584, Attention: Appeals Unit]* **(800) 368-3238**.

[(VI) For members with medical coverage through Aetna—

(a) First and second level appeals must be submitted in writing to—

Aetna
Appeals Resolution Team
PO Box 14463
Lexington, KY 40512
or by fax to (859) 425-3379

(b) Expedited appeals must be communicated by calling (800) 245-0618 or by submitting a written fax to (859) 425-3379, Attention: Appeals Resolution Team.]

C. The internal review process for adverse benefit determinations relating to pharmacy and the Pharmacy Lock-In Program consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals. Pharmacy appeals and Pharmacy Lock-In Program appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, and any applicable reason(s) relevant to the appeal including: the reason(s) the member believes the claim should be paid, the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63116-6588
or by fax to (877) 852-4070

(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—

Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121

(IV) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

(V) The Pharmacy Benefit Manager will respond to Pharmacy Lock-In Program appeals in writing to the member within thirty (30) days from the date the Pharmacy Benefit Manager received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
http://www.externalappeal.com/

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines. Decisions concerning eligibility for Medicare primary members may not be able to be granted pursuant to these guidelines if the decision is contrary to the rules controlling eligibility for Medicare Advantage plan as put forth by Centers for Medicare and Medicaid. Valid proof of eligibility must be included with the appeal if the enrollment request includes addition of dependent(s). Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction:

(J) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier, except that no changes will be considered for HSA Plan elections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan; **and**

(K) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancelation or an appeal of a deadline that is statutorily mandated*[; and]***.**

[(L) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment.]

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

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Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members. The Missouri Consolidated Health Care Plan is amending section (1).

*PURPOSE: This amendment updates the Medicare Part D coverage stage amounts and copayment amounts***.**

(1) The pharmacy benefit for Medicare primary non-active members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non–Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and Medicaid Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach *[three thousand eight hundred twenty dollars ($3,820)]* **four thousand twenty dollars ($4,020)**, the member will pay the following copayments:

A. Preferred Formulary Generic Drugs: thirty-one- (31-) day supply has a ten dollar ($10) copayment; sixty- (60-) day supply has a twenty dollar ($20) copayment; ninety- (90-) day supply at retail has a thirty dollar ($30) copayment; and a ninety- (90-) day supply through home delivery has a twenty-five dollar ($25) copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a forty dollar ($40) copayment; sixty- (60-) day supply has an eighty ($80) dollar copayment; ninety- (90-) day supply at retail has a one hundred twenty ($120) dollar copayment; and a ninety- (90-) day supply through home delivery has a one hundred ($100) dollar copayment; and

C. Non-preferred Formulary Drugs and approved excluded drugs: thirty-one- (31-) day supply has a one hundred dollar ($100) copayment; sixty- (60-) day supply has a two hundred dollar ($200) copayment; ninety- (90-) day supply at retail has a three hundred dollar ($300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar ($250) copayment;

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[three thousand eight hundred twenty dollars ($3,820)]* **four thousand twenty dollars ($4,020)** and remain below *[five thousand one hundred dollars ($5,100)]* **six thousand three hundred fifty dollars ($6,350)**, the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach *[five thousand one hundred dollars ($5,100)]* **six thousand three hundred fifty dollars ($6,350)**;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[five thousand one hundred dollars ($5,100)]* **six thousand three hundred fifty dollars ($6,350)**, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[three dollar and forty cent ($3.40)]* **three dollar and sixty cent ($3.60)** copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or an *[eight dollar and fifty cent ($8.50)]* **eight dollar and ninety-five cent ($8.95)** copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage; and

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

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Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment adds coinsurance dollar limits for the Health Savings Account (HSA) Plan, revises services covered at one hundred percent (100%), makes a technical correction to (1)(B)2.B., and renumbers as necessary.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider to non-Medicare primary members.

(A) PPO 750 Plan and PPO 1250 Plan.

1. Network:

A. Preferred formulary generic drug copayment: Ten Dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and thirty dollars ($30) for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Preferred formulary brand drug copayment: Forty dollars ($40) for up to a thirty-one- (31-) day supply; eighty dollars ($80) for up to a sixty- (60-) day supply; and one hundred twenty dollars ($120) for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Specialty drug copayment: Seventy-five dollars ($75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

E. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply and charged a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped and the member will be charged the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: Ten dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and twenty-five dollars ($25) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: Forty dollars ($40) for up to a thirty-one- (31-) day supply; eighty dollars ($80) for up to a sixty- (60-) day supply; and one hundred dollars ($100) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary;

(d) Specialty drug copayment: Seventy-five dollars ($75) for up to a thirty-one- (31-) day supply; one hundred fifty ($150) for up to sixty (60-) day supply; and two hundred twenty-five ($225) for up to ninety- (90-) day supply for a specialty drug on the formulary;

G. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

H. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

I. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied;

J. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

K. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum;

L. Preferred select brand drugs, as determined by the PBM: Ten dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and twenty-five dollars ($25) for up to a ninety- (90-) day supply; and

M. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Vaccine recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

[(II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;]

*[(III)]***(II)** Prescribed preferred diabetic test strips and lancets; and

*[(IV)]***(III)** One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Network individual—four thousand one hundred fifty dollars ($4,150).

D. Network family—eight thousand three hundred dollars ($8,300).

E. Non-network—no maximum.

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-2.053.

1. Network:

A. Preferred formulary generic drug: Ten percent (10%) coinsurance **up to fifty dollars ($50) per thirty-one- (31-) day supply** after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: Twenty percent (20%) coinsurance **up to one hundred dollars ($100) per thirty-one- (31-) day supply** after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met**, not to exceed:**

(I) Twenty-five dollars ($25) per thirty-one- (31-) day supply for generic drugs;

(II) Fifty dollars ($50) per thirty-one- (31-) day supply for preferred formulary brand drug; and

(III) One hundred dollars ($100) per thirty-one- (31-) day supply for non-preferred formulary drug;

E. Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment;

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. *[The following are also covered at one hundred percent (100%) when filled at a network pharmacy:]*

*[(I)]***G.** Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention **are covered at one hundred percent (100%) when filled at a network pharmacy**; *[and]*

[(II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;]

*[G.]***H.** The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer; **and**

*[H.]***I.** If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.110 General Foster Parent Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (3), (5), and (14).

PURPOSE: This amendment revises default enrollment procedures, clarifies disabled dependent eligibility, reporting of other health coverage, and renumbers as necessary.

(3) Enrollment Procedures.

(C) An eligible foster parent may elect or change coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

1. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the eligible foster parent's responsibility to notify MCHCP of the life event;

A. If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

2. Employer-sponsored group coverage loss. An eligible foster parent or his/her spouse/child(ren) may enroll within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances:

A. Employer-sponsored medical, dental, or vision plan terminates;

B. Eligibility for employer-sponsored coverage ends;

C. Employer contributions toward the premiums end; or

D. Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

3. If an eligible foster parent or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

4. If an eligible foster parent or eligible foster parent's spouse receives a court order stating s/he is responsible for covering a child, the eligible foster parent may enroll the child in an MCHCP plan within sixty (60) days of the court order; or

5. Default Enrollment

A. If an eligible foster parent is enrolled in the PPO *[300 or]* **750,** PPO *[600]* **1250, or HSA** Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled **in the same plan enrolled in the prior year** at the same level of coverage *[in the PPO 1250 Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year]*; or

[B. If an eligible foster parent is enrolled in the Health Savings Account (HSA) Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the HSA Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year;]

*[C.]***B.** If an eligible foster parent is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year; or

6. If an eligible foster parent submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the foster parent of such by mail, phone, or secure message. The foster parent must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date MCHCP notifies the foster parent, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals

whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(E) Disabled Dependent.

1. A**n** *[newly]* eligible foster parent may enroll his/her permanently disabled child **when first eligible** or an enrolled permanently disabled dependent turning age twenty-six (26) years, may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the end of the month of the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of *[a new foster parent and his/her]* **the** permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled child's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(14) Members are required to disclose to the claims administrator whether they have other health coverage and, if so, information about the coverage. *[A member may submit other coverage information to the claims administrator by phone, fax, mail, or online. Dependent claims will be denied until the information is received.]* Once the information is received, claims will be reprocessed subject to all applicable rules.

AUTHORITY: sections 103.059 and 103.078, RSMo 2016. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (5) and (13).

PURPOSE: This amendment clarifies disabled dependent eligibility and reporting of other health coverage.

(5) Proof of Eligibility.

(F) Disabled dependent.

1. A**n** *[new]* employee may enroll his/her permanently disabled child **when first eligible** or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the end of the month of the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of *[a new employee and his/her]* **the** permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(13) Members are required to disclose to the claims administrator whether or whether not they have other health coverage and, if so, information about the coverage. *[A member may submit this information to the claims administrator by phone, fax, mail, or online. Dependent claims will be denied if the disclosure is not made.]* Once the information is received, claims will be reprocessed subject to all applicable rules.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RESCISSION

22 CSR 10-3.045 Plan Utilization Review Policy. This rule established the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded to reflect changes due to a new third party administrator.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Oct. 30, 2019, effective Jan. 1, 2020, expired June 28, 2020. Rescinded: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization—The claims administrator must authorize some services in advance. Preauthorization is to determine if the procedure or treatment is medically necessary. The claims administrator will determine what procedures or treatments are subject to preauthorization. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, or who are enrolled in the Medicare Advantage Plan are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. A list of medical services for which preauthorization is required may be obtained at any time from the claims administrator.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization requests will be made within thirty-six (36) hours, which will include one (1) business day of the receipt of the request. If the information necessary to make a benefit determination is not received, the claims administrator will notify the member and provider of any necessary extension. The provider will be given forty-five (45) calendar days from receipt of the extension notice to respond with additional information. Once the information is received or the forty-five (45) days have elapsed, a determination will be made within thirty-six (36) hours which will include one (1) business day.

B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than one (1) business day of the receipt of all necessary information;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision;

(C) Retrospective Review—Reviews to determine coverage after services have been provided to a member. The retrospective review is not limited to an evaluation of medical necessity, reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment. The claim administrator shall have the authority to correct payment errors when identified under retrospective review;

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment; and

(E) Case Management—A voluntary process to assess, coordinate, and evaluate options and services of members with catastrophic and complex illnesses. A case manager will help members understand what to expect during the course of treatment, help establish collaborative goals, complete assessments to determine needs, interface with providers, and negotiate care. Members are identified for case management through claim information, length of hospital stay, or by referral. The case manager will dismiss the member from case management once the case manager determines that objectives have been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Rescinded and readopted: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (3), (13), (14), (18), and adding section (9).

PURPOSE: This amendment revises the Health Savings Account (HSA) Plan individual family member out-of-pocket maximum, adds one hundred percent (100%) coverage after deductible is met for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, services performed in another country, and renumbers as necessary.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—four thousand nine hundred fifty dollars ($4,950);

2. Network out-of-pocket maximum for family—nine thousand nine hundred dollars ($9,900). Any individual family member need only incur a maximum of *[seven thousand nine hundred dollars ($7,900)]* **eight thousand one hundred fifty dollars ($8,150)** before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual—nine thousand nine hundred dollars ($9,900); and

4. Non-network out-of-pocket maximum for family—nineteen thousand eight hundred dollars ($19,800).

(9) Sterilization procedure for men is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

*[(9)]***(10)** Newborn's claims will be subject to deductible and coinsurance.

*[(10)]***(11)** Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

*[(11)]***(12)** Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

*[(12)]***(13)** Maximum plan payment—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claims administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

*[(13)]***(14)** Any claim must be initially submitted within twelve (12) months following the date of service**, unless otherwise specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

*[(14)]***(15)** For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

*[(15)]***(16)** A subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section *[(16)]* **(17)** of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare (unless Medicare is secondary coverage to MCHCP);

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-purpose health FSA, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

*[(16)]***(17)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

*[(17)]***(18)** Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

PURPOSE: This amendment revises the medical plan benefits for transition of care, allergy testing and immunotherapy, bariatric surgery, bone growth stimulators, cardiac rehabilitation, chelation therapy, chiropractic services, cochlear implant, dental care, emergency room services, genetic counseling, hearing aids, hospice care and palliative services, hospital, injections, maternity coverage, nutrition therapy, orthognathic or jaw surgery, orthotics, and renumbers as necessary.

[(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. The rate of payment during the transitional period shall be the same fee paid prior to leaving the network. Benefits eligible for transition of care include:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;

(C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;

(D) Home nursing care;

(E) Radiation therapy;

(F) Dialysis;

(G) Durable medical equipment;

(H) Cancer treatment;

(I) Clinical trials;

(J) Physical, speech, or occupational therapy;

(K) Hospice care;

(L) Bariatric surgery, and follow-up per criteria covered under the plan;

(M) Inpatient hospitalization at the time of the network change;

(N) Mental health services; or

(O) Related follow-up services within three (3) months of an acute injury or surgery.]

(2) Transition of Care. A transition of care option is available for members who seek to continue to remain under the care of an non-network provider who was treating them prior to the provider losing network status. A subscriber and his/her dependents may request to continue receiving care at the network benefit level. If approved, the member will be eligible to continue care with the current non-network provider at the network benefit level for a period of time until it is medically appropriate for the member to transfer care to a network provider. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. The following benefits are eligible for transition of care as determined by the claims administrator:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their third trimester of pregnancy;

(C) Radiation therapy;

(D) Dialysis;

(E) Cancer treatment;

(F) Physical, speech, or occupational therapy;

(G) Hospice care;

(H) Inpatient hospitalization at the time of the network change; or

(I) Mental health services.

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250, and HSA Plan.

[(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.]

*[(E)]***(D)** Plan benefits for the PPO 750 Plan, PPO 1250, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms*[. The following tests and treatments are covered:]***;**

[A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or

(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or

(II) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;]

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism;

4. Bariatric surgery*[. Bariatric surgery is covered when all of the following requirements have been met:]***;**

[A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is

available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;]

5. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

6. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit*[. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:]*;

[A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;]

7. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

8. Cardiac rehabilitation*[. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:]*;

[A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;]

9. Chelation therapy*[. The administration of FDA-approved chelating agents is covered for any of the following conditions:]*;

[A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;]

10. Chiropractic services*[. Chiropractic]*—manipulation and adjunct therapeutic procedures/modalities *[(e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:]*;

[A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed homecare program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);]

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant *[device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:]* **and auditory brainstem implant;**

[A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional

and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;]

13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. Treatment must be initiated within sixty (60) days of accident; and

(II) Restorative services limited to dental implants when needed as a result of *[cancerous or non-cancerous]* tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. Diabetes Self-Management Education;

15. Dialysis is covered when received through a network provider;

16. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

17. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit*[. Hospital and ancillary charges are paid as a network benefit]*;

18. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement within one (1) year following cataract surgery;

19. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

20. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing*[.]***;**

[A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azoopermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;]

21. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

22. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

23. Hair prostheses. Prostheses and expenses for scalp hair

prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

24. Hearing aids (per ear). Hearing aids *[are]* covered **once every two (2) years** for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

[A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years.] If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

*[(I)]***A.** Conventional: one thousand dollars ($1,000).

*[(II)]***B.** Programmable: two thousand dollars ($2,000).

*[(III)]***C.** Digital: two thousand five hundred dollars ($2,500).

*[(IV)]***D.** Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

25. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

26. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

27. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill *[and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.]***;**

[A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;]

28. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services *[are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:]***; and**

[(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and]

(V) Outpatient mental health services *[are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:]***;**

[(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;]

29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

30. Injections. See preventive services for coverage of vaccinations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit*[.]***;**

[A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastomosis status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Ideopathic progressive polyneuropathy;]

31. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

32. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to *[the]* **applicable copayments,** deductible**,** and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

33. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

34. Nutrition therapy*[.]***;**

[A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral

feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;]

35. Office visit. Member encounter with a provider for health care, mental health, or substance use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

36. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

37. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. *[Cancerous or non-cancerous t]***T**umors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical *[or physiological]* abnormality *[when one (1) of the following criteria is met:]***;**

[(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibularfossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;]

38. Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with agoniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered *[for members who meet the following criteria:]***.**

[(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.]

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

39. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. Online weight management program offered through the plan's exclusive provider arrangement;

40. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

41. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

42. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

43. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

44. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

45. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

46. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

47. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original

rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.058 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (5), (11), (12), and (14).

PURPOSE: This amendment adds one hundred percent (100%) coverage for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, and services performed in another country for the PPO 750 Plan.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; *[and]*

(D) Four (4) Diabetes Self-Management Education visits*[.]***; and**

(E) Sterilization procedure for men.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claim administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service**, unless otherwise specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-*[2.055]***3.057**. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.059 PPO 1250 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (5), (11), (12), and (14).

PURPOSE: This amendment adds one hundred percent (100%) coverage for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, and services performed in another country for the PPO 1250 Plan.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; *[and]*

(D) Four (4) Diabetes Self-Management Education visits*[.]***; and**

(E) Sterilization procedure for men.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claim administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service**, unless otherwise specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-*[2.055]* **3.057**. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.061 Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment revises the following benefits not payable by the plan: alternative therapies, assistant surgeon services, birthing center, home births, nocturnal enuresis alarm, therapy, vaccinations requested by a third party, and renumbers as necessary.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-3.057 or 22 CSR 10-3.090.

(C) Alternative therapies—that are outside conventional medicine *[including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback]* **as determined by the claims administrator**.

[(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.]

*[(F)]***(E)** Athletic enhancement services and sports performance training.

*[(G)]***(F)** Autopsy.

[(H) Birthing center.]

*[(I)]***(G)** Blood donor expenses.

*[(J)]***(H)** Blood pressure cuffs/monitors.

*[(K)]***(I)** Care received without charge.

*[(L)]***(J)** Charges exceeding the vendor contracted rate or benefit limit.

*[(M)]***(K)** Charges resulting from the failure to appropriately cancel a scheduled appointment.

*[(N)]***(L)** Childbirth classes.

*[(O)]***(M)** Comfort and convenience items.

*[(P)]***(N)** Cosmetic procedures.

*[(Q)]***(O)** Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

*[(R)]***(P)** Dental care, including oral surgery.

*[(S)]***(Q)** Devices or supplies bundled as part of a service are not separately covered.

*[(T)]***(R)** Dialysis received through a non-network provider.

*[(U)]***(S)** Educational or psychological testing unless part of a treatment program for covered services.

*[(V)]***(T)** Examinations requested by a third party.

*[(W)]***(U)** Exercise equipment.

*[(X)]***(V)** Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

*[(Y)]***(W)** Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

*[(Z)]***(X)** Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

*[(AA)]***(Y)** Health and athletic club membership—including costs of enrollment.

*[(BB)]***(Z)** Hearing aid replacement batteries.

[(CC) Home births.]

*[(DD)]***(AA)** Infertility treatment beyond the covered services to diagnose the condition.

*[(EE)]***(BB)** Infusions received through a non-network provider.

*[(FF)]***(CC)** Level of care, greater than is needed for the treatment of the illness or injury.

*[(GG)]***(DD)** Long-term care.

*[(HH)]***(EE)** Maxillofacial surgery.

*[(II)]***(FF)** Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

*[(JJ)]***(GG)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

*[(KK)]***(HH)** Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

*[(LL)]***(II)** Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

[(MM) Nocturnal enuresis alarm.]

*[(NN)]***(JJ)** Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

*[(OO)]***(KK)** Non-medically necessary services.

*[(PP)]***(LL)** Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

*[(QQ)]***(MM)** Non-reusable disposable supplies.

*[(RR)]***(NN)** Online weight management programs.

*[(SS)]***(OO)** Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the

plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

*[(TT)]***(PP)** Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, nonsedating antihistamines, unless otherwise covered as a preventive service.

*[(UU)]***(QQ)** Physical and recreational fitness.

*[(VV)]***(RR)** Private-duty nursing.

*[(WW)]***(SS)** Routine foot care without the presence of systemic disease that affects lower extremities.

*[(XX)]***(TT)** Services obtained at a government facility if care is provided without charge.

*[(YY)]***(UU)** Sex therapy.

*[(ZZ)]***(VV)** Surrogacy—pregnancy coverage is limited to plan member.

*[(AAA)]***(WW)** Telehealth site origination fees or costs for the provision of telehealth services are not covered.

[(BBB) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.]

*[(CCC)]***(XX)** Travel expenses.

[(DDD) Vaccinations requested by third party.]

*[(EEE)]***(YY)** Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment revises the order of benefit determination rules and renumbers as necessary.

(3) Order of Benefit Determination Rules.

(B) Rules. MCHCP determines its order of benefits *[using the first of the following rules which applies]* **as follows**:

[1. Active/inactive employee. The benefits of the plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of the plan which covers that person as a laid off or retired employee (or as that employee's dependent);

2. Nondependent/dependent. The benefits of the plan which covers the person as an employer or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent;]

1. Non-Dependent/Dependent.

A. The plan which covers the member as an employee or subscriber is primary.

B. The plan which covers the member as dependent is secondary;

2. Active/layoff. The plan that covers the member or dependent through the member's active employment is primary to a plan that covers the member or dependent through the member's status as a laid off employee;

3. Retiree. The plan that covers the member or dependent through the member's active employment is primary to a plan that covers the member or dependent through the member's status as a retiree;

*[3.]***4.** Medicare.

A. If a member is an active employee and has Medicare, MCHCP is the primary plan for the active employee and his/her dependents. Medicare is the secondary plan except for members with end stage renal disease (ESRD) as defined in subparagraph (3)(B)*[3.]***4.**C.

B. If a member is a retiree and has Medicare, Medicare is the primary plan for the retiree and his/her Medicare-eligible dependents. MCHCP is the secondary plan.

C. If a member or his/her dependents are eligible for Medicare solely because of ESRD, the member's MCHCP plan is primary to Medicare during the first thirty (30) months of Medicare eligibility for home peritoneal dialysis or home hemodialysis and thirty-three (33) months for in-center dialysis. After the thirty (30) or thirty-three (33) months, Medicare becomes primary, and claims are submitted first to Medicare, then to MCHCP for secondary coverage. The member is responsible for notifying MCHCP of his/her Medicare status;

*[4.]***5.** Dependent child/parents not separated or divorced. When MCHCP and another plan cover the same child as a dependent of different *[persons, called]* parents—

A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

B. If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time;

*[5.]***6.** Dependent child/separated or divorced, or never married. If two (2) or more plans cover a person as a dependent child of divorced, separated, or never married parents, benefits for the child are determined in this order—

A. First, the plan of the parent with custody of the child;

B. Then, the plan of the spouse of the parent with the custody of the child;

C. Then, the plan of the parent not having custody of the child; and

D. Finally, the plan of the spouse of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;

*[6.]***7.** Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (3)(B)*[4.]***5.**;

*[7.]***8.** Dependent child/parents both parents covered by MCHCP. If both parents are covered by MCHCP and both parents cover the child as a dependent, MCHCP will not coordinate benefits with itself;

*[8.]***9.** *[The plan that covers the member as a spouse is primary over the plan that covers the member as a dependent child]* **When an adult dependent is covered by both spouse and parent, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term**; and

*[9.]***10.** Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term.

*AUTHORITY: sections 103.059[, RSMo 2000,] and [section] 103.089, RSMo [Supp. 2013] **2016**. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (1), (3), and (5).

PURPOSE: This amendment revises the claim submission and initial benefit determinations time frames, updates the name and appeal contact information for the third party administrator.

(1) Claims Submissions and Initial Benefit Determinations.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than *[fifteen (15) days]* **twenty (20) business days** from the date the vendor receives the claim. The vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days if, for reasons beyond the vendor's control, the decision cannot be made within the first *[fifteen (15)]* **twenty (20)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)]* **twenty-(20-)** day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the

vendor. The vendor then must decide the claim no later than *[fifteen (15)]* **thirty (30)** days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor *[as soon as possible thereafter]* **within three (3) business days**.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than *[thirty (30) days]* **twenty (20) business days** after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-) day]* **twenty (20-) day** period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15) days]* **thirty (30) days** after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously approved course of treatment in sufficient time to allow the member, or the member's provider, to appeal and obtain a determination before the benefit is reduced or terminated.

(3) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply:

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage after an individual has been covered under the plan;

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination;

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative;

4. External review. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by *[UMR]* **Anthem** and Express Scripts, Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time);

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law;

6. Final external review decision. A final external review decision means a determination rendered under the external review process at the conclusion of an external review; and

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect, except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect; or

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review, except as specifically provided in 22 CSR 10-3.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being

appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be *[responded to in writing to the member]* **decided** within *[thirty (30)]* **twenty (20) business** days *[for post-service claims and fifteen (15) days for pre-service claims]* from the date the vendor received the first level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)]* **twenty- (20-)** day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15)]* **thirty (30)** days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first. **Written confirmation of the decision will be sent by the vendor within fifteen (15) business days.**

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) *[working]* **business** days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals *[shall]* **will** be *[responded to in writing to the member]* **decided** within *[thirty (30)]* **twenty (20)** days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)]* **twenty- (20-)** day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15)]* **thirty (30)** days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first. **Written confirmation of the decision will be sent by the vendor within fifteen (15) business days.**

(V) For members with medical coverage through *[UMR]* **Anthem**—

(a) First and second level pre-service**, first and second level post-service,** and concurrent claim appeals must be submitted in writing to—

[UMR Appeals
PO Box 400046
San Antonia, TX 78229
or by fax to (888) 615-6584]

Anthem Blue Cross and Blue Shield
Attn: Grievance Department
PO Box 105568
Atlanta, Georgia 30348-5568
or by fax to (800) 859-3046

[(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546
or by fax to (877) 291-3248]

*[(c)]***(b)** Expedited *[pre-service]* appeals *[must]* **may** be *[communicated]* **submitted** by calling *[(800) 808-4424, ext. 15227]* **(877) 333-7488** or by submitting a written fax to *[(888) 615-6584, Attention: Appeals Unit]* **(800) 368-3238**.

C. The internal review process for adverse benefit determinations relating to pharmacy and the Pharmacy Lock-In Program consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals. Pharmacy appeals and Pharmacy Lock-In Program appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, and any applicable reason(s) relevant to the appeal including: the reason(s) the member believes the claim should be paid, the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63116-6588
or by fax to (877) 852-4070

(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—

Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121

(IV) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

(V) The Pharmacy Benefit Manager will respond to Pharmacy Lock-In Program appeals in writing to the member within thirty (30) days from the date the Pharmacy Benefit Manager received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
http://www.externalappeal.com/

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:

(I) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan; **and**

(J) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated*[; and]*.

[(K) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment.]

*AUTHORITY: section 103.059, RSMo [2000] **2016**. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment adds coinsurance dollar limits for the Health Savings Account (HSA) Plan, revises services covered at one hundred percent (100%), and renumbers as necessary.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider.

(A) PPO 750 Plan and PPO 1250 Plan Prescription Drug Coverage.

1. Network.

A. Preferred formulary generic drug copayment: Ten Dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and thirty dollars ($30) for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. Preferred formulary brand drug copayment: Forty dollars ($40) for up to a thirty-one- (31-) day supply; eighty dollars ($80) for up to a sixty- (60-) day supply; and one hundred twenty dollars ($120) for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Specialty drug (as designated as such by the PBM) copayment: Seventy-five dollars ($75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

E. Diabetic drug (as designated as such by the PBM) copayment: Fifty percent (50%) of the applicable network copayment.

F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescription(s) will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has

been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: Ten dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and twenty-five dollars ($25) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: Forty dollars ($40) for up to a thirty-one- (31-) day supply; eighty dollars ($80) for up to a sixty- (60-) day supply; and one hundred dollars ($100) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary.

(d) Specialty drug (as designated as such by the PBM) copayment: Seventy-five dollars ($75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

G. Diabetic drug (as designated as such by the PBM) copayment: Fifty percent (50%) of the applicable network copayment.

H. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

I. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied.

J. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

K. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum.

L. Preferred select brand drugs, as determined by the PBM: Ten dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and twenty-five dollars ($25) for up to a ninety- (90-) day supply;

M. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Vaccine recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

[(II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;]

*[(III)]***(II)** Prescribed preferred diabetic test strips and lancets; and

*[(IV)]***(III)** One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Network individual—four thousand one hundred fifty dollars ($4,150).

D. Network family—eight thousand three hundred dollars ($8,300).

E. Non-network—no maximum.

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. Preferred formulary generic drug: Ten percent (10%) coinsurance **up to fifty dollars ($50) per thirty-one- (31-) day supply** after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: Twenty percent (20%) coinsurance **up to one hundred dollars ($100) per thirty-one- (31-) day supply** after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met*[.]***, not to exceed:**

(I) Twenty-five dollars ($25) per thirty-one- (31-) day supply for generic drugs;

(II) Fifty dollars ($50) per thirty-one- (31-) day supply for preferred formulary brand drug; and

(III) One hundred dollars ($100) per thirty-one- (31-) day supply for non-preferred formulary drug;

E. Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through network home delivery for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. *[The following are also covered at one hundred percent (100%) when filled at a network pharmacy:]*

*[(I)]***G.** Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention **are covered at one hundred percent (100%) when filled at a network pharmacy**; and

[(II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;]

*[G.]***H**. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer;

*[H.]***I.** If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: Fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order or rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety-(90-) day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 2—DEPARTMENT OF AGRICULTURE
Division 90—Weights, Measures and Consumer Protection
Chapter 10—Liquefied Petroleum Gases

ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Safety Commission under section 323.020, RSMo 2016, the commission amends a rule as follows:

2 CSR 90-10.001 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2019 (44 MoReg 2240). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The commission received one (1) comment on the proposed amendment.

COMMENT #1: Staff noticed that the statute 323.101, RSMo was removed by mistake.
RESPONSE AND EXPLANATION OF CHANGE: The commission agrees and will be adding the statute back in the authority.

2 CSR 90-10.001 Definitions and General Provisions

AUTHORITY: sections 323.010 and 323.030, RSMo 2016. Original rule filed Oct. 15, 2008, effective March 30, 2009. Amended: Filed June 13, 2011, effective Jan. 30, 2012. Amended: Filed June 26, 2012, effective Jan. 30, 2013. Amended: Filed June 16, 2014, effective Jan. 30, 2015. Non-substantive change filed July 1, 2016, published Aug. 31, 2016. Amended: Filed July 1, 2016, effective Feb. 28, 2017. Amended: Filed July 10, 2019.

Title 2—DEPARTMENT OF AGRICULTURE
Division 90—Weights, Measures and Consumer Protection
Chapter 10—Liquefied Petroleum Gases

ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Safety Commission under section 323.020, RSMo 2016, the commission adopts a rule as follows:

2 CSR 90-10.019 LP Gas Containers **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 15, 2019 (44 MoReg 2240-2241). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 400—Office of Educator Quality

ORDER OF RULEMAKING

By the authority vested in the State Board of Education under sections 161.092, 168.011, 168.071, and 168.081, RSMo 2016, and section 168.021, RSMo Supp. 2019, the board amends a rule as follows:

5 CSR 20-400.180 Temporary Authorization Certificate of License to Teach **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2019 (44 MoReg 2000-2002). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 400—Office of Educator Quality

ORDER OF RULEMAKING

By the authority vested in the State Board of Education under sections 161.092, 168.011, 168.071, 168.081, 168.400, 168.405, and 168.409, RSMo 2016, and section 168.021, RSMo Supp. 2019, the board amends a rule as follows:

5 CSR 20-400.610 Certification Requirements for Initial Administrator Certificate (School Leader Kindergarten – Grade 12) **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2019 (44 MoReg 2002-2009). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The department received ninety-nine (99) comments on this proposed amendment.

COMMENTS #1-94: Each comment was received from an individual educator, which stated that all new school administrators should have at least five (5) years of teaching experience.
RESPONSE: While the department acknowledges the importance of teaching experience, and is increasing from two (2) years to three (3) years of experience it declines the recommendation to increase to five (5) years. The department believes that an increase from two (2) years to three (3) years of teaching experience is sufficient for the preparation and development of a leader. No changes have been made to the amendment as a result of these comments.

COMMENTS #95-99: Each comment was received from an individual educator, which stated that all new school administrators should have completed a minimum of ten (10) years of teaching experience.
RESPONSE: While the department acknowledges the importance of teaching experience, the increase from two (2) years to three (3) years of experience it declines the recommendation to increase to ten (10) years. The department believes that an increase from two (2) years to three (3) years of teaching experience is sufficient for the preparation and development of a leader. No changes have been made to the amendment as a result of these comments.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission amends a rule as follows:

10 CSR 10-5.442 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 1, 2019 (44 MoReg 1269-1272). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program (APCP) received a total of five (5) comments on this rulemaking. Four (4) comments on this rulemaking were from the U.S. Environmental Protection Agency (EPA) and one (1) comment was from department staff.

Due to similar concerns expressed in the following two (2) comments, one (1) response that addresses these concerns is at the end of these two (2) comments.
COMMENT #1: The department is proposing to amend the applicability in subsection (1)(A) to apply to just those installations that are existing as of November 30, 2019. 10 CSR 10-5.442 was approved by EPA into the State Implementation Plan (SIP) on January 23, 2012 (77 FR 3144) as meeting the volatile organic compound Reasonably Available Control Technology (RACT) requirements for ozone in St. Louis, Missouri. The department has previously interpreted the RACT requirements as only applying to those installations that were existing at the time of the rule's promulgation and that any applicable source beginning operations after that date would be required to go through New Source Review. EPA recommends the department either change the proposed applicability date to the effective date of the rule when promulgated as meeting the RACT requirements, which was August 30, 2011, or provide an explanation to EPA that the department has changed its interpretation of the applicability of RACT. A change in interpretation may affect EPA's action on other SIP submissions made by the department.
COMMENT #2: Department staff commented that the date proposed in subsection (1)(A) should be the effective date of the rule, January 30, 2020.
RESPONSE AND EXPLANATION OF CHANGE: Amendments to this rule that became effective August 30, 2011 addressed an updated Control Techniques Guideline issued by EPA in 2006 for Lithographic Printing and Letterpress Printing Materials. These amendments provided more stringent RACT control levels and represent RACT under the 8-hour ozone National Ambient Air Quality Standards (NAAQS) in effect at the time of approval into the SIP by EPA in January 2012. The department agrees with EPA's comment that the applicability of this rule should apply to sources existing at the time when the rule became effective for the most recent amendments approved into the SIP by EPA. As a result of this comment, subsection (1)(A) has been revised to change the applicability date to that for installations existing on August 30, 2011.

COMMENT #3: The department is proposing to incorporate by reference (IBR) in subsection (5)(E) EPA's memorandum titled, Potential to Emit (PTE) Guidance for Specific Source Categories (April 14, 1998), and provides a location where copies of the memorandum can be obtained from the National Technical Information Service (NTIS). However, EPA does not believe that the memorandum can be obtained from NTIS, nor can EPA recommend a publication office to replace the NTIS reference. The memorandum was sent from EPA's Office of Air Quality Planning Standards and Office of Regulatory Enforcement to various Division Directors at EPA and was not a document published with a publication number. EPA suggests that instead of incorporating a memorandum or guidance, which typically is nonbinding on states or sources of air pollutants into its rules, that the department codify the portions of the memorandum it would like to enforce.
RESPONSE AND EXPLANATION OF CHANGE: The department appreciates EPA's comment and has reviewed the memorandum titled, Potential to Emit (PTE) Guidance for Specific Source Categories (April 14, 1998). In addition, further documentation was examined regarding the thresholds in subsection (5)(E) of this rule and their connection to the memorandum. The department has determined that the memorandum should not be incorporated by reference because it is being used as a support document with no identical thresholds to what's currently in 10 CSR 10-5.442. As a result of this comment, subsection (5)(E) has been revised to remove IBR information.

COMMENT #4: The Rulemaking Report for this proposed rulemaking states that the rule changes are not incorporating information by reference. As mentioned in a previous comment on this rule, the department is proposing to IBR an EPA memorandum. Even if the department believes that this proposed rule amendment simply clarifies location information for a memorandum that was already in the rule, EPA suggests the department revise its Rulemaking Report for enhanced clarity to the public.
RESPONSE: The department appreciates EPA's comment and has removed IBR information from this proposed rule amendment from subsection (5)(E) due to Comment #3. The department continues to update necessary references to federal provisions in this proposed amendment with a citation to 10 CSR 10-6.030, section (22), where IBR material may be found. In this proposed rule amendment, with

regard to the reference to 10 CSR 10-6.030, the department is not incorporating by reference information and is only indicating where IBR material may be found. No changes were made to the Rulemaking Report as a result of this comment.

COMMENT #5: There are several references to 10 CSR 10-6.030, section (22) throughout the proposed rule amendment. However, section (22) does not exist in the state's SIP-approved rule 10 CSR 10-6.030, Sampling Methods for Air Pollution Sources and that those proposed rule changes have already been made available for public comment. As such, the EPA would not act on a SIP submission amending 10 CSR 10-5.442 until an amendment for 10 CSR 10-6.030 is also submitted to EPA for SIP approval.
RESPONSE: Amendments to rule 10 CSR 10-6.030 Sampling Methods for Air Pollution Sources were recently adopted on July 25, 2019. The submittal to EPA of the amendments to 10 CSR 10-6.030 is planned in November 2019 and will occur before the submittal to EPA of amendments to 10 CSR 10-5.442. No changes were made to rule text as a result of this comment.

10 CSR 10-5.442 Control of Emissions From Lithographic and Letterpress Printing Operations

(1) Applicability.

(A) This rule applies to installations that operate offset lithographic printing presses, letterpress printing presses, or both, including heatset web, non-heatset web (newspaper and non-newspaper), and non-heatset sheet-fed presses in St. Louis City and Jefferson, St. Charles, Franklin, and St. Louis Counties existing on August 30, 2011.

(5) Test Methods. Certain test methods mentioned in this rule may be found in 10 CSR 10-6.030. Other U.S. Environmental Protection Agency test methods specific to this rule may be found in 40 CFR 60, Appendix A as specified in 10 CSR 10-6.030(22).

(E) Material Use Guidance: Applicability Determination. Based on EPA's *Potential to Emit (PTE) Guidance for Specific Source Categories* (April 14, 1998), and the equations of paragraph (5)(D)3. of this rule, the methods in this subsection may be used for determining if a facility or press meets the corresponding applicability thresholds.

1. For determining if a facility meets the applicability limits of subsection (1)(B) of this rule, the material use thresholds are as follows:

Type of Printing Operation	12-Month Rolling Material Use Threshold
Sheet-fed	768 gallons of cleaning solvent and fountain solution additives
Non-heatset Web	768 gallons of cleaning solvent and fountain solution additives
Heatset Web	5,400 pounds of ink, cleaning solvent, and fountain solution additives

2. For determining if a web heatset press is subject to subsection (3)(C) of this rule, the material use thresholds are as follows:

Type of Printing Press	Annual Material Use Threshold
Heatset Web	55,800 pounds of ink

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission amends a rule as follows:

10 CSR 10-5.550 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 1, 2019 (44 MoReg 1272-1275). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received nine (9) comments from two (2) sources: department staff, and the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following two (2) comments, one (1) response that addresses these concerns is at the end of these two (2) comments.
COMMENT #1: Since proposal of this rule amendment, department staff noted that the date proposed in subsection (1)(A) should be the effective date of the rule, January 30, 2020.
COMMENT #2: At subsection (1)(A), the department is proposing to revise the applicability of the rule to just those installations that are existing as of November 30, 2019. 10 CSR 10-5.550 was approved by the EPA in 2000 as meeting the volatile organic compound (VOC) Reasonably Available Control Technology (RACT) requirements for ozone in St. Louis (see 65 CFR 31489 (May 18, 2000)). The department has previously interpreted the RACT requirements as only applying to those installations that were existing at the time of the rule's promulgations as RACT and that any applicable source beginning operations after that date would be required to go through New Source Review (NSR). The EPA recommends that the department either change the proposed applicability date to the effective date of the rule when promulgated as meeting the RACT requirements (February 29, 2000) or provide an explanation to the EPA that it has changed its interpretation of the applicability of RACT. A change in interpretation may affect the EPA's action on other SIP submissions made by the department.
RESPONSE AND EXPLANATION OF CHANGE: The department reviewed the applicability date and agrees with EPA's comment that the applicability of this rule should apply to sources existing at the time when the rule became effective as approved in the State Implementation Plan (SIP) by EPA. As a result of these comments, subsection (1)(A) has been revised to change the applicability date to that for installations existing on February 29, 2000.

COMMENT #3: There are several references to 10 CSR 10-6.030(22) throughout the rule revision; however, section (22) does not exist in the state's SIP approved 10 CSR 10-6.030 Sampling Methods. The EPA understands that the department is in the process of revising 10 CSR 10-6.030 Sampling Methods and that those proposed rule changes have already been made available for public comment. As such, the EPA would not act on a SIP submission revising 10 CSR 10-5.550 until a submission revising 10 CSR 10-6.030 is also submitted to the EPA for SIP approval.
RESPONSE: Amendments to rule 10 CSR 10-6.030 Sampling Methods for Air Pollution Sources were recently adopted on July 25, 2019. The submittal to EPA of the amendments to 10 CSR 10-6.030 is planned in November 2019 and will occur before the submittal to

EPA of amendments to 10 CSR 10-5.550. No changes were made to the rule text as a result of this comment.

COMMENT #4: The EPA recommends that the department reconsider its Incorporation By Reference (IBR) of the *Code of Federal Regulations* (CFR) specifically, 40 CFR Part 63, in whole in subsection (2)(I) of the rule. Incorporating 40 CFR Part 63 in whole would be unusual as the department already selectively incorporates individual technology standards in 10 CSR 10-6.070 and 6.080. The EPA recommends, if the department intends to continue to incorporate requirements of the CFR by reference, that the incorporations be very specific. The EPA recommends that the department consider incorporating by reference only the sample method related requirements of 40 CFR Part 63 into the Missouri Air Conservation Commission rule. For example, the department could incorporate by reference Appendix A to Part 63—Test Methods.
RESPONSE AND EXPLANATION OF CHANGE: The department has revised the IBR in the rule to be specific to Method 301 of 40 CFR 63 as suggested. This clarifies the intent of the IBR. As a result of this comment, subsection (2)(I) has been revised.

COMMENT #5: Additionally, if the intent of adding subsections 10 CSR 10-6.030 Sampling Methods is to minimize the number of locations where the department must update IBR references, then the EPA believes that adding — 40 CFR 63 promulgated as of July 1, 2018, is hereby incorporated by reference in this rule, — is unnecessary to add to subsection (2)(I) as the sampling requirement IBR will already be at 10 CSR 10-6.030.
RESPONSE: Rule 10 CSR 10-6.030 does not IBR 40 CFR 63 and therefore the IBR in subsection (2)(I) is necessary. No changes were made to the rule text as a result of this comment.

COMMENT #6: At subsection (2)(M), the department is proposing to include IBR information for Appendix A to the EPA's Control Technology Guidelines (CTG) Control of Volatile Organic Compound Emissions from Reactor Processes an Distillation Operations Processes in the Synthetic Organic Chemical Manufacturing Industry, EPA-450/4-91-031 (as published by EPA August 1993) and states that copies of the CTG can be obtained from the NTIS. However, the EPA does not believe that the CTG can be obtained from the NTIS. It is possible that the document can be found on the EPA's electronic library National Service Center for Environmental Publications (https:/www.epa.gov/nscep). The EPA suggests that instead of incorporating a guidance (which typically is nonbinding on states or sources of air pollutants) into its rules, that the department codify portions of the guidance that it would like to enforce.
RESPONSE AND EXPLANATION OF CHANGE: The department revised the IBR of EPA-450/4-91-031 to the address for the National Service Center for Environmental Publications for those persons wanting to obtain a copy of the document. As a result of this comment, subsection (2)(M) has been revised.

COMMENT #7: The EPA recommends that the department review its IBR of the CTG publication at subsection (2)(N) for the same reasons as noted above.
RESPONSE: The change to subsection (2)(M), as explained in the department's response to comment #6, addresses EPA's comment for the IBR of the document. No changes were made to the rule text as a result of this comment.

COMMENT #8: At subparagraph (3)(A)1.B. the department proposes to add — as specified in 10 CSR 10-6.070(1)(A) — to the rule text; however, a review of 10 CSR 10-6.070, effective February 28, 2019, shows that 10 CSR 10-6.070 does not have a subsection (1)(A). It is possible that this is a typographical error, but the EPA could not discern what the correct citation should have been to make a recommendation for correction.
RESPONSE AND EXPLANATION OF CHANGE: The department reviewed the reference in the proposed rule and found that 40 CFR 60.18 would need to be IBR instead of referencing rule 10 CSR 10-6.070. As a result of this comment, subparagraph (3)(A)1.B. has been revised.

COMMENT #9: The Rulemaking Report for this action states that the rule changes are not incorporating information by reference. As mentioned above, the department is proposing to IBR an EPA guideline and 40 CFR Part 63 in whole. Even if the department believes that this proposed rule revision clarifies that the guidelines and CFR citation were already IBR, the EPA suggests the department revise its Rulemaking Report for enhanced clarity to the public.
RESPONSE: The department acknowledges that the IBR of 40 CFR 63 was not reflected in the Rulemaking Report. This omission was not intentional. The IBR was printed in the *Missouri Register* as part of the rulemaking and public notification process allowing interested parties an opportunity to view and comment on the proposal. No changes were made to the rule text as a result of this comment.

10 CSR 10-5.550 Control of Volatile Organic Compound Emissions From Reactor Processes and Distillation Operations Processes in the Synthetic Organic Chemical Manufacturing Industry

(1) Applicability.

(A) The provisions of this rule apply to any vent stream originating from a process unit with a reactor process or distillation operation located in St. Louis City and Jefferson, St. Charles, Franklin and St. Louis Counties existing on February 29, 2000.

(2) Definitions.

(I) Halogenated vent stream—Any vent stream determined to have a total concentration of halogen atoms (by volume) contained in organic compounds of two hundred (200) parts per million by volume or greater determined by Method 18 of 40 CFR part 60, Appendix A, as specified in 10 CSR 10-6.030(22), or other test or data validated by Method 301 of 40 CFR part 63, Appendix A, or by engineering assessment or process knowledge that no halogenated organic compounds are present. Method 301 of 40 CFR 63, Appendix A, promulgated as of July 1, 2018 is hereby incorporated by reference in this rule, as published by the Office of the Federal Register. Copies can be obtained from the U.S. Publishing Office Bookstore, 710 N. Capitol Street NW, Washington DC 20401. This rule does not incorporate any subsequent amendments or additions. For example, one hundred fifty (150) parts per million by volume of ethylene dichloride would contain three hundred (300) parts per million by volume of total halogen atoms.

(M) Process unit—Equipment assembled and connected by pipes or ducts to produce, as intermediates or final products, one or more SOCMI chemicals included in Appendix A of Control of Volatile Organic Compound Emissions from Reactor Processes and Distillation Operations Processes in the Synthetic Organic Chemical Manufacturing Industry, EPA-450/4-91-031. Appendix A of Control of Volatile Organic Compound Emissions from Reactor Processes and Distillation Operations Processes in the Synthetic Organic Chemical Manufacturing Industry, EPA-450/4-91-031 promulgated August 1993 is hereby incorporated by reference in this rule. Copies can be obtained from the National Service Center for Environmental Publications (NSCEP), PO Box 42419, Cincinnati, Ohio 45242-0419. This rule does not incorporate any subsequent amendments or additions. A process unit can operate independently if supplied with sufficient feed or raw materials and sufficient product storage facilities.

(3) General Provisions.

(A) Control Requirements.

1. For individual vent streams within a process unit with a TRE

index value less than or equal to one (1.0), the owner or operator shall—

A. Reduce emissions of TOC (less methane and ethane) by ninety-eight (98) weight-percent, or to twenty (20) parts per million by volume, on a dry basis corrected to three percent (3%) oxygen, whichever is less stringent. If a boiler or process heater is used to comply with this paragraph, then the vent stream shall be introduced into the flame zone of the boiler or process heater; or

B. Combust emissions in a flare. Flares used to comply with this paragraph shall comply with the requirements of 40 CFR 60.18. 40 CFR 60.18 promulgated as of July 1, 2018 is hereby incorporated by reference in this rule, as published by the Office of the Federal Register. Copies can be obtained from the U.S. Publishing Office Bookstore, 710 N. Capitol Street NW, Washington DC 20401. The flare operation requirement does not apply if a process, not subject to this rule, vents an emergency relief discharge into a common flare header and causes the flare servicing the process subject to this rule to be out of compliance with one (1) or more of the provisions of the flare operation rule.

2. For each individual vent stream(s) within a process unit with a TRE index value greater than one (1.0), the owner or operator shall maintain vent stream parameters that result in a calculated total resource effectiveness greater than one (1.0) without the use of a volatile organic compound control device. The TRE index shall be calculated at the outlet of the final recovery device.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission amends a rule as follows:

10 CSR 10-6.050 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on June 3, 2019 (44 MoReg 1543-1544). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received six (6) comments from six (6) sources: the Northrop Grumman Company; Newman, Comley, and Ruth P.C.; the Regulatory Environmental Group for Missouri (REGFORM); Kansas City Power and Light (KCP&L), Associated Electric Cooperative, Inc. (AECI), and the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: Northrop Grumman commented on the use of "as soon as possible, but no more than two business days" in the rule text. They requested instead the text of "as soon as possible, but no more than two business days of discovery." Excess emissions may occur without knowledge of the reporting individual or responsible parties and discovery of the excess emissions could not be known nor reported to the Air Pollution Control Program within two business days of the occurrence of the excess emission.

COMMENT #2: Newman, Comley, and Ruth commented on behalf on the Missouri Agribusiness Association (MO-AG) on the proposed revisions to the rule to require malfunction reporting "as soon as possible, but no more than two (2) business days." The current rule only requires malfunction reports within two business days. MO-AG opposes the as soon as possible requirement. As soon as possible is a subjective term that will likely lead to increased enforcement actions against regulated entities who report in less than two (2) business days but not as soon as possible in the department's opinion. Two (2) days is a short period of time and should be sufficient to allow the department to respond to malfunction events.

COMMENT #3: REGFORM commented on the proposed revisions to the rule to require facilities to report excess emissions caused by a malfunction "as soon as possible, but no more than two (2) business days." The current rule requires that malfunction reports be submitted within two (2) business days. REGFORM opposes the as soon as possible requirement since the current language effectively and clearly conveys the urgency of prompt reporting. Any additional environmental benefit is minimal at best. The obvious downside to the proposed amendment is that the as soon as possible language is a subjective term that could easily lead to increased enforcement actions against regulated entities who report in less than two (2) business days, but not as soon as possible in the department's opinion. REGFORM has no alternative language to suggest. Rather, REGFORM suggests that this seems like a great opportunity to just leave it alone unless the APCP can cite specific examples of real environmental harm necessitating a rule change. The proposal also seems an unlikely candidate to satisfy the provisions of Executive Order 17-03 for Red Tape Reduction. REGFORM respectively recommends that this provision in section (3) of the proposed amendment be withdrawn.

COMMENT #4: KCP&L commented on the proposed revisions to the rule to require facilities to report excess emissions caused by a malfunction "as soon as possible, but no more than two (2) business days." The current rule requires than malfunction reports be submitted within two (2) business days. In the view of KCP&L, the proposed revision to the rule fails to meaningfully improve response times while introducing unnecessary uncertainty to what is currently a clear and conclusive standard. KCP&L believes that the existing language sufficiently communicates the intent of the regulation and are proposing no alternative. KCP&L respectfully recommends that this provision in section (3) of the proposed amendment be withdrawn.

COMMENT #5: AECI commented that they do not support the APCP's proposed revision to include language stating notification shall be given "as soon as possible, but no more than" two (2) business days of the release. The language should remain as is, with no modification. The as soon as possible language seems to be contrary to the goal of the Red Tape Reduction initiative to, among other things, reduce confusing language and ambiguity. The proposed language would seem to leave interpretation of the rule's intent up to debate and subjectively, potentially placing regulated entities at undue risk of enforcement. The requirement for reporting should remain well defined, within "two (2) business days." It is difficult to imagine the protection of human health and the environment being enhanced with the implementation of the proposed changed to the rule. AECI recommends that the as soon as possible language be withdrawn from the amended rule.

RESPONSE AND EXPLANATION OF CHANGE: The department reviewed the comments on the addition of the as soon as possible language to the rule text. Although the additional language was intended to bring clarity to the regulated community, the comments received on the proposed language confirmed that the addition of the as soon as possible language would have minimal impact on promptly reporting malfunction events. As a result of these comments, the rule text was changed to remove the as soon as possible language from the rule text.

COMMENT #6: The EPA sent a letter to the Air Pollution Control Program that stated that they had no comments on the rulemaking.

RESPONSE: The department appreciates the EPA reviewing the proposed rulemaking. No changes were made to the rule text as a result of this comment.

10 CSR 10-6.050 Start-Up, Shutdown, and Malfunction Conditions

(3) General Provisions.

(A) In the event of a malfunction which results in excess emissions that exceeds one (1) hour, the owner or operator of such facility shall notify the Missouri Department of Natural Resources' Air Pollution Control Program in the form of a written report submitted within two (2) business days. The written report shall include, at a minimum, the following:

1. Name and location of installation;
2. Name and telephone number of person responsible for the installation;
3. Name of the person who first discovered the malfunction and precise time and date that the malfunction was discovered;
4. Identity of the equipment causing the excess emissions;
5. Time and duration of the period of excess emissions;
6. Cause of the excess emissions;
7. Air pollutants involved;
8. Estimate of the magnitude of the excess emissions expressed in the units of the applicable requirement and the operating data and calculations used in estimating the magnitude;
9. Measures taken to mitigate the extent and duration of the excess emissions; and
10. Measures taken to remedy the situation which caused the excess emissions and the measures taken or planned to prevent the recurrence of these situations.

(B) The owner or operator shall notify the Missouri Department of Natural Resources' Air Pollution Control Program at least ten (10) days prior to any maintenance, start-up, or shutdown activity, which is expected to cause an excess release of emissions that exceeds one (1) hour. If notification cannot be given ten (10) days prior to any maintenance, start-up, or shutdown activity, which is expected to cause an excess release of emissions that exceeds one (1) hour, notification shall be given as soon as practicable prior to the maintenance, start-up, or shutdown activity. If prior notification is not given for any maintenance, start-up, or shutdown activity which resulted in an excess release of emissions that exceeded one (1) hour, notification shall be given within two (2) business days of the release. In all cases, the notification shall be a written report and include, at a minimum, the following:

1. Name and location of installation;
2. Name and telephone number of person responsible for the installation;
3. Identity of the equipment involved in the maintenance, start-up, or shutdown activity;
4. Time and duration of the period of excess emissions;
5. Type of activity and the reason for the maintenance, start-up, or shutdown;
6. Type of air contaminant involved;
7. Estimate of the magnitude of the excess emissions expressed in the units of the applicable emission control regulation and the operating data and calculations used in estimating the magnitude;
8. Measures taken to mitigate the extent and duration of the excess emissions; and
9. Measures taken to remedy the situation which caused the excess emissions and the measures taken or planned to prevent the recurrence of these situations.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission amends a rule as follows:

10 CSR 10-6.140 Restriction of Emissions Credit for Reduced Pollutant Concentrations From the Use of Dispersion Techniques **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on June 3, 2019 (44 MoReg 1544-1547). No changes were made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received one (1) comment from one (1) source: the U.S. Environmental Protection Agency (EPA).

COMMENT #1: The EPA sent a letter to the Air Pollution Control Program that stated that they had no comments on the rulemaking.
RESPONSE: The department appreciates the EPA reviewing the proposed rulemaking. No changes were made to the rule text as a result of this comment.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 10—Office of the Director
Chapter 15—Abortions

ORDER OF RULEMAKING

By the authority vested in the Missouri Department of Health and Senior Services under section 192.006, RSMo 2016, and House Bill 10, 100th General Assembly, First Regular Session, the department amends a rule as follows:

19 CSR 10-15.060 Prohibition on Expenditure of Funds **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2019 (44 MoReg 2123-2124). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received no comments.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 20—Division of Community and Public Health
Chapter 20—Communicable Diseases

ORDER OF RULEMAKING

By the authority vested in the Missouri Department of Health and Senior Services under sections 192.006 and 192.020, RSMo 2016, the department amends a rule as follows:

19 CSR 20-20.020 Reporting Infectious, Contagious, Communicable, or Dangerous Diseases **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1,

2019 (44 MoReg 2124-2125). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received two (2) letters with a total of four (4) comments.

COMMENT #1: Jon Mooney, Assistant Director of the Springfield-Greene County Health Department, and Sarah Willson, Vice President of Clinical and Regulatory Affairs for the Missouri Hospital Association, expressed concern that a one (1) day reporting requirement would likely increase the number of potential cases reported, which would potentially increase the number of false positives.
RESPONSE: The department does not agree that there would be an increase in false positives. The department does not solely rely on test results to make a determination. The department also reviews other factors, such as the symptoms of a patient in making its determination in accordance with the national surveillance case definition. As a result, the department does not anticipate an increase in false positives. No changes were made as a result of this comment.

COMMENT #2: Jon Mooney also expressed concern that additional testing will likely add more than five hundred dollars ($500) cost to the healthcare system.
RESPONSE: The department does not agree that there will be an added cost to the healthcare system. This rule change does not require any additional testing. No changes were made as a result of this comment.

COMMENT #3: Jon Mooney questioned whether Legionellosis should be transitioned to a one (1) day requirement based on both the ubiquitous nature of the bacteria and the lack of person-to-person disease transmission, which make the spread of the disease slower than other common one (1) day reportable conditions.
RESPONSE: The department understands Mr. Mooney's concern. Although there is a wide range of one (1) day reportable conditions, due to the high mortality rate of Legionnaires' Disease, the department has determined that moving Legionellosis to a one (1) day report will allow the department to better protect the public. Additionally, other states currently list Legionellosis as a one (1) day reportable condition. No changes were made as a result of this comment.

COMMENT #4: Jon Mooney requests that, in the event that Legionellosis is moved to the one (1) day reporting requirement, DHSS policy and procedure place a decreased response-time on the epidemiological process. He provided details of a recent investigation.
RESPONSE: The department recognizes Mr. Mooney's concern, however, there is no need for change in department policy and procedure. Legionellosis investigations are already initiated on the same day as a report is received. No changes were made as a result of this comment.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 20—Division of Community and Public Health
Chapter 20—Communicable Diseases

ORDER OF RULEMAKING

By the authority vested in the Missouri Department of Health and Senior Services under sections 192.006 and 192.020, RSMo 2016, the department amends a rule as follows:

19 CSR 20-20.040 Measures to Determine the Prevalence and Prevent the Spread of Diseases which are Infectious, Contagious, Communicable, or Dangerous in their Nature **is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2019 (44 MoReg 2125-2126). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received two (2) letters with four (4) comments.

COMMENT #1: Jon Mooney with Springfield-Greene County Health comments that the amendments to 19 CSR 20-20.040 are not changing any of the department's authority but rather adding more detailed information on notification and mitigation that may be required. Mr. Mooney cautions the department as to its response during investigations as a response too aggressive or too cautious can result in adverse consequences for the health and safety of his community and others across the state. Mr. Mooney cites two (2) examples of responses by the department during investigations to show that there needs to be better communication/dialogue between the department, the health department and community partners.
RESPONSE: The department understands Mr. Mooney's concerns. The department investigates each case separately and determines any responses based on the facts and situation of each case. Regulation 19 CSR 20-20.040 allows for a coordinated response by the department and the local public health agencies. Some situations allow for more dialogue than other situations depending on the urgency of each case investigation. No changes were made as a result of this comment.

COMMENT #2: Sarah Willson with the Missouri Hospital Association comments that she welcomes discussion with the department surrounding investigation, notification, and mitigation processes. Ms. Willson would like this dialogue with the department to better understand the procedural implementation of the changes made to the rule focusing on notification and mitigation. Ms. Willson recognizes the urgency related to certain reports, but cautions that the department must communicate and act based on sound, reasonable, and accepted principles.
RESPONSE: The department understands Ms. Willson's request that the department interact with the hospitals to discuss the procedural implementation of the changes and that the department communicate with the hospitals during investigations. No changes were made as a result of this comment.

COMMENT #3: Jon Mooney with Springfield-Greene County Health suggests that the department listing specific control measures and vague guidance in subsection (2)(G) is confusing. Mr. Mooney recommends either specifically listing all of the control measures that may be used by the department or staying with a broader guidance throughout the item.
RESPONSE: The department is generally listing control measures in subsection (2)(G). This may include notice to individuals or the public as a method to control the disease, such as in an outbreak. This section is meant to be broad. The department listed the notice option as a method to control an outbreak in order to alert the public that this may be one method used as a control measure. No changes were made as a result of this comment.

COMMENT #4: Jon Mooney with Springfield-Greene County Health comments that sections (6) and (7) seem redundant and unnecessary. Mr. Mooney recommends either their removal or clarification as to the need to include these sections.
RESPONSE: The department concludes sections (6) and (7) are not

redundant and unnecessary. Section (6) mirrors the department's statutory authority and gives a general overview of the department's duties. In contrast, section (7) creates a new duty of notification for the department or the local health authority. Although section (7) could be potentially used in section (6); section (7) now creates a requirement for each case or outbreak which subjects individuals to serious illness or death, if acquired. No changes were made as a result of this comment.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 95—Medical Marijuana

ORDER OF RULEMAKING

By the authority vested in the Division of Regulation and Licensure under Art. XIV Mo.Cont., the division adopts a rule as follows:

19 CSR 30-95.010 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2019 (44 MoReg 1875-1878). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received two (2) comments on the proposed rule, both from the DHSS Section for Medical Marijuana Regulation.

COMMENT #1: The rule should include a definition for "employment rate." Suggested language: "Employment rate" means the percent of the civilian labor force that is employed.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language clarifies the proposed rule in that the term "employment rate" is not defined, and applying the proposed definition to the term, where applicable, results in the effect intended by the proposed rule. The rule is amended as suggested.

COMMENT #2: The definition for "seed-to-sale tracking system" in .010(36) should be modified to match the way that term is used throughout Chapter 95. Specifically, the definition should not include the statewide track and track system
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language clarifies the proposed rule. The use of the term "seed-to-sale tracking system" throughout the applicable rules does not apply to the statewide track and trace system. The rule is amended as suggested.

19 CSR 30-95.010 Definitions

(13) "Employment rate" means the percent of the civilian labor force that is employed.

(14) "Entity" means a natural person, corporation, professional corporation, nonprofit corporation, cooperative corporation, unincorporated association, business trust, limited liability company, general or limited partnership, limited liability partnership, joint venture, or any other legal entity.

(15) "Flowering plant" means a marijuana plant from the time it exhibits the first signs of sexual maturity through harvest.

(16) "Harvest lot" means a specifically identified quantity of marijuana that is uniform in strain, cultivated utilizing the same growing practices, harvested within a seventy-two- (72-) hour period at the same location, and cured under uniform conditions.

(17) "Identification card" means a document, whether in paper or electronic format, issued by the department that authorizes a qualifying patient, primary caregiver, or employee or contractor of a licensed facility to access medical marijuana as provided by law.

(18) "Liquid Capital" means any asset in the form of cash or that can be converted into cash quickly with little or no loss in value, including stocks and marketable securities, government bonds, mutual funds, money-market funds, and certificates of deposit.

(19) "Majority owned" means more than fifty percent (50%) of the economic interests and more than fifty percent (50%) of the voting interests of an entity, including any parent and subsidiary entities.

(20) "Marijuana" or "Marihuana" means *Cannabis indica*, *Cannabis sativa*, and *Cannabis ruderalis*, hybrids of such species, and any other strains commonly understood within the scientific community to constitute marijuana, as well as resin extracted from the plant and marijuana-infused products. "Marijuana" or "Marihuana" does not include industrial hemp containing a crop-wide average tetrahydrocannabinol concentration that does not exceed three-tenths of one percent (0.3%) on a dry weight basis, or commodities or products manufactured from industrial hemp.

(21) "Marijuana-Infused Products" means products that are infused with marijuana or an extract thereof and are intended for use or consumption other than by smoking, including, but not limited to, edible products, ointments, tinctures, and concentrates.

(22) "Medical Marijuana Cultivation Facility" means a facility licensed by the department, to acquire, cultivate, process, store, transport, and sell marijuana to a medical marijuana dispensary facility, medical marijuana testing facility, or to a medical marijuana-infused products manufacturing facility.

(23) "Medical Marijuana Dispensary Facility" means a facility licensed by the department, to acquire, store, sell, transport, and deliver marijuana, marijuana-infused products, and drug paraphernalia used to administer marijuana as provided for in this section to a qualifying patient, a primary caregiver, another medical marijuana dispensary facility, a medical marijuana testing facility, or a medical marijuana-infused products manufacturing facility.

(24) "Medical Marijuana-Infused Products Manufacturing Facility" means a facility licensed by the department, to acquire, store, manufacture, transport, and sell marijuana-infused products to a medical marijuana dispensary facility, a medical marijuana testing facility, or to another medical marijuana-infused products manufacturing facility.

(25) "Medical Marijuana Testing Facility" means a facility certified by the department to acquire, test, certify, and transport marijuana.

(26) "Medical Marijuana Transportation Facility" means a facility certified by the department to transport marijuana to a qualifying patient, a primary caregiver, a medical marijuana cultivation facility, a medical marijuana-infused products manufacturing facility, a medical marijuana dispensary facility, a medical marijuana testing facility, or another medical marijuana-transportation facility.

(27) "Medical use" means the production, possession, delivery, distribution, transportation, or administration of marijuana or a marijuana-infused product, or drug paraphernalia used to administer marijuana or a marijuana-infused product, for the benefit of a qualifying patient to mitigate the symptoms or effects of the patient's qualifying medical condition.

(28) "Non-emancipated qualifying patient" means a qualifying patient under the age of eighteen (18) who has not been emancipated

under Missouri law.

(29) "Physician" means an individual who is licensed and in good standing to practice medicine or osteopathy under Missouri law.

(A) A license is in good standing if it is registered with the Missouri Board of Healing Arts as current, active, and not restricted in any way, such as by designation as temporary or limited.

(B) Practice of medicine or osteopathy means practice by persons who hold a physician and surgeon license pursuant to Chapter 334, RSMo, including those who are admitted to practice in Missouri by reciprocity pursuant to 334.043, RSMo.

(30) "Physician certification" means a document, whether handwritten, electronic or in another commonly used format, signed by a physician and stating that, in the physician's professional opinion, the patient suffers from a qualifying medical condition.

(31) "Primary caregiver" means an individual twenty-one (21) years of age or older who has significant responsibility for managing the well-being of a qualifying patient and who is designated as such on the primary caregiver's application for an identification card under this section or in other written notification to the department.

(32) "Principal officers or managers" means persons who, regardless of title, have responsibility for supervising the management, administration, or operation of an entity, including, but not limited to: presidents, vice presidents, or general counsels; chief executive, financial, or operating officers; general partners, managing partners, or controlling partners; managing-members; or trustees.

(33) "Process lot" means, once production is complete, any amount of medical marijuana concentrate or extract of the same type and processed using the same extraction methods, standard operating procedures, and harvest lots; or any amount of medical marijuana infused product of the same type and processed using the same ingredients, standard operating procedures, and harvest lots.

(34) "Public place" means any public or private property, or portion of public or private property, that is open to the general public, including but not limited to, sidewalks, streets, bridges, parks, schools, and businesses. However, for purposes of designating a nonpublic place within a public place, the owner or entity with control of any such property may, but is not required to, provide one (1) or more enclosed, private spaces where one (1) qualifying patient and, if required by the owner or entity with control of any such property, a representative of such owner or entity, may congregate for the qualifying patient to consume medical marijuana. The qualifying patient may be accompanied by the family of the qualifying patient, the qualifying patient's primary caregiver, and/or the qualifying patient's physician. The owner or entity with control of any such property may provide such a space by individual request or designate such a space for ongoing use and may limit use of medical marijuana in that space to uses that do not produce smoke. Any such permission shall be given in writing and provided to the qualifying patient or publicly posted prior to a qualifying patient's use of medical marijuana in that space.

(35) "Qualifying medical condition" means the condition of, symptoms related to, or side-effects from the treatment of—

(A) Cancer;

(B) Epilepsy;

(C) Glaucoma;

(D) Intractable migraines unresponsive to other treatment;

(E) A chronic medical condition that causes severe, persistent pain or persistent muscle spasms, including, but not limited to, those associated with multiple sclerosis, seizures, Parkinson's disease, and Tourette's syndrome;

(F) Debilitating psychiatric disorders, including, but not limited to, post-traumatic stress disorder, if diagnosed by a state licensed psychiatrist;

(G) Human immunodeficiency virus or acquired immune deficiency syndrome;

(H) A chronic medical condition that is normally treated with a prescription medication that could lead to physical or psychological dependence, when a physician determines that medical use of marijuana could be effective in treating that condition and would serve as a safer alternative to the prescription medication;

(I) Any terminal illness; or

(J) In the professional judgment of a physician, any other chronic, debilitating or other medical condition, including, but not limited to, hepatitis C, amyotrophic lateral sclerosis, inflammatory bowel disease, Crohn's disease, Huntington's disease, autism, neuropathies, sickle cell anemia, agitation of Alzheimer's disease, cachexia, and wasting syndrome.

(36) "Qualifying Patient" means a Missouri resident diagnosed with at least one (1) qualifying medical condition.

(37) "Seed-to-sale tracking system" means a software system designed to perform functions necessary to fulfill a licensed or certified facility's responsibilities in tracking medical marijuana from either the seed or immature plant stage until the medical marijuana is sold to a qualifying patient or primary caregiver.

(38) "Signature" means a handwritten or electronic signature.

(39) "Statewide track and trace system" means the system the department uses to track medical marijuana from either the seed or immature plant stage until the medical marijuana is sold to a qualifying patient or primary caregiver to ensure that all medical marijuana sold in Missouri was cultivated or manufactured in Missouri, that all medical marijuana cultivated or manufactured in Missouri is sold only by dispensaries and only to individuals in possession of a valid qualifying patient or primary caregiver identification card, and that any given qualifying patient or primary caregiver is only purchasing the amount of medical marijuana he or she is approved to purchase at any given time.

(40) "Substantially common control, ownership, or management" means—

(A) The possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of an entity, by any means, including ownership, contract, financing, or otherwise;

(B) The legal or beneficial ownership, directly or indirectly through ownership of an affiliate entity, of ten percent (10%) or more of an entity's outstanding voting stock or other ownership interest;

(C) The ownership, directly or indirectly through the ownership of an affiliate entity, of a majority of the capital assets, real property assets, or leasehold interests; or

(D) The ability to make policy decisions, operating decisions, or decisions regarding the allocation of income and expenses for the entity, whether directly or by a management agreement.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 95—Medical Marijuana

ORDER OF RULEMAKING

By the authority vested in the Division of Regulation and Licensure under Art. XIV Mo. Cont. the division adopts a rule as follows:

19 CSR 30-95.025 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2019 (44

MoReg 1878-1885). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received ten (10) comments on the proposed rule, all from the DHSS Section for Medical Marijuana Regulation.

COMMENT #1: 19 CSR 30-95.025(4)(A)3. contains a typo in the included citation. The correct citation is 19 CSR 30-95.040(3)(C)-(D).
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the comment is accurate. The rule is amended as suggested.

COMMENT #2: 19 CSR 30-95.025(4)(A)5. should be clarified by replacing the current language with the following: That the entity can comply with any local government zoning laws specific to the entity's type of facility other than applicable local government requirements regarding proximity to schools, daycares, or churches.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language clarifies the proposed rules. Zoning laws regarding proximity to schools, daycares, or churches are already requested elsewhere in this section. The intent of 19 CSR 30-95.025(4)(A)5. was not to ask for the same information again but rather for any other applicable zoning regulations, and the suggested language makes that clear. The rule is amended as suggested.

COMMENT #3: 19 CSR 30-95.025(4)(C)2.B. should be clarified. Where "must" appears, the more appropriate word to use is "should." Further, the existing language about obscuring certain information is confusing and should be replaced with specific instructions about what information should be redacted.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested changes clarify the proposed rule. The suggested changes better reflect the intent of the proposed rule and also match the guidance issued by the department during the facility application process regarding the department's interpretation. The rule is amended as suggested.

COMMENT #4: 19 CSR 30-95.025(4)(C)6. should be clarified to acknowledge this step comes after when facilities have been both ranked and scored.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language clarifies the proposed rule. The rule is amended as suggested.

COMMENT #5: 19 CSR 30-95.025(4)(C)8. contains a typo. The correct paragraph number to cite is paragraph 6. not 7.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the comment is accurate. The rule is amended as suggested.

COMMENT #6: 19 CSR 30-95.025(4)(D) should be modified to allow for filling license/certification openings that occur during the issuance process. This can be accomplished by adding a new provision after 19 CSR 30-95.025(4)(D)2., which should say "All facilities that are issued a license or certification will be given forty-eight (48) hours to confirm they accept the license or certification. If a facility does not accept issuance of a license or certification, the license or certification will be offered to the next ranked facility, as applicable, until all available licenses and certifications are issued and accepted."
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language addresses administrative efficiency and also the purpose of the Article XIV. Administrative efficiency is served by allowing a potential licensee to choose not to accept a license so that the license may be offered to another entity from the same application round instead of opening an entirely new application round to fill that license. This also serves the apparent intent of Article XIV that a certain minimum number of licenses be actually issued. The rule is amended as suggested.

COMMENT #7: 19 CSR 30-95.025(5)(A) should be clarified to ensure understanding that the legal limit referenced is the possessor's legal limit.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language clarifies the proposed rule. The rule is amended as suggested.

COMMENT #8: 19 CSR 30-95.025(5)(C)2. contains a typo. The citation should be to 19 CSR 30-95.040(1)(F)7., not 19 CSR 30-95.040(1)(E)7.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the comment is accurate. The rule is amended as suggested.

COMMENT #9: 19 CSR 30-95.025(5)(C)1. should be modified to include a one thousand dollar penalty, not a two hundred dollar penalty.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language establishes a penalty more appropriate to the seriousness of the action. The rule is amended as suggested.

COMMENT #10: 19 CSR 30-95.025(7)(A) should be clarified. The services referenced should be seed-to-sale tracking services, not seed-to-sale services.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language clarifies the proposed rule and also makes it consistent with the related rule. The rule is amended as suggested.

19 CSR 30-95.025 Generally Applicable Provisions

(4) Facility Evaluation Criteria. All applicants for cultivation, dispensary, manufacturing, testing, or transportation licenses or certifications will be evaluated for whether they meet minimum standards as described in subsection (A) of this section. During application time periods where more qualified applicants apply for cultivation, dispensary, manufacturing, or testing licenses or certifications than there are licenses or certificates available in that category, the department will use a system of numerically scoring ten (10) additional evaluation criteria to rank the applications in each such license or certification category against each other.

(A) The minimum standards for licenses and certifications can be met by providing all material required by 19 CSR 30-95.040(2) in order to show, as applicable—

1. Authorization to operate as a business in Missouri;

2. That the entity is majority owned by natural persons who have been residents of Missouri for at least one (1) year;

3. That the entity is not under substantially common control as another entity or a combination of other entities in violation of 19 CSR 30-95.040(3)(C)-(D);

4. That the entity is not within one thousand (1000) feet of an existing elementary or secondary school, daycare, or church, or, if a local government allows for closer proximity to schools, daycares, and churches, that the entity complies with the local government's requirements;

5. That the entity can comply with any local government zoning laws specific to the entity's type of facility other than applicable local government requirements regarding proximity to schools, daycares, or churches; and

6. That the entity will not be owned, in whole or in part, or have as an officer, director, board member, or manager, any individual with a disqualifying felony offense.

(B) The additional evaluation criteria, which will be numerically scored, are—

1. The character, veracity, background, qualifications, and relevant experience of principal officers or managers;

2. The business plan proposed by the applicant, which in the case of cultivation facilities and dispensaries shall include the ability to maintain an adequate supply of medical marijuana, plans to ensure safety and security of qualifying patients and the community, procedures to be used to prevent diversion, and any plan for making medical marijuana available to low-income qualifying patients;

3. Site security;

4. Experience in a legal cannabis market;

5. In the case of testing facilities, the experience of the facility's personnel with the health care industry and with testing marijuana, food, or drugs for toxins and/or potency;

6. The potential for the facility to have a positive economic impact in the site community;

7. In the case of cultivation facilities, capacity or experience with agriculture, horticulture, and health care;

8. In the case of dispensary facilities, capacity or experience with health care, the suitability of the proposed location, and its accessibility for patients;

9. In the case of infused products manufacturing facilities, capacity or experience with food and beverage manufacturing; and

10. Maintaining competitiveness in the medical marijuana marketplace.

(C) When applicable, numerical scoring of evaluation criteria will be conducted as follows:

1. Applications will be separated from their identifying information, including facility business names, and names, addresses, and Social Security numbers of individuals, and assigned a numerical identifier for use during scoring;

2. Applications will be scored based on responses to evaluation criteria questions. Responses may take the form of written answers or written answers with attachments.

A. Each type of facility or certification application will be scored and ranked against the other applications of the same type. For dispensaries, applications will be scored and ranked against other dispensary applications in the same congressional district.

B. Applications will be scored without reference to the identities of the facilities or of individuals named in an application. Written responses to evaluation criteria questions should not refer to facility business names, either legal or fictitious, and should refer to all individuals by title and initials only, e.g. "Owner A.E.M." or "Principal Officer R.W.M." If it is necessary to refer to facility business names or to any individuals in order to properly answer evaluation criteria questions, the facility business names and any names, addresses, or social security number of individuals must be redacted from the evaluation criteria question response. Unredacted versions of those same documents will be submitted separately in a section of the application designated for this purpose.

C. Responses to evaluation criteria questions in which a business or individual is identified by name will not be scored;

3. Evaluation criteria questions and initial scoring shall be as delineated in the Evaluation Criteria Questions and Points table, the Evaluation Criteria Scoring table, and the Evaluation Criteria Topics and Values Table, which are incorporated by reference in this rule as published by the department and available on the department's website at http://medicalmarijuana.mo.gov. This rule does not incorporate any subsequent amendments or additions;

4. The same evaluation criteria question in each application will be scored by the same individual, if possible, and scores that vary significantly from other scores for the same questions may be rescored. If rescored, the first score will be discarded, and the second score will stand;

5. Once all applications have been assigned an initial rank and score, the department will reconnect the applications with their identifying information;

6. After evaluation criteria questions have been initially ranked and scored, and in order to award points to applicants that seek to locate in economically distressed areas, thereby supporting a potential for positive economic impact in the site community, the facility rankings will be further adjusted by awarding additional points as follows:

A. Any facility seeking a license to locate within a zip code area that has an employment rate of eighty-five percent to eighty-nine and nine tenths percent (85-89.9%) will receive a scoring increase of thirty percent (30%) of the average initial score of all applicants of the same facility type within the evaluation criteria topic regarding potential for positive economic impact in the site community; and

B. Any facility seeking a license to locate within a zip code area that has an employment rate of zero to eighty-four and nine tenths percent (0-84.9%) will receive a scoring increase of forty percent (40%) of the average initial score of all applicants of the same facility type within the evaluation criteria topic regarding potential for positive economic impact in the site community; and

C. For the purposes of this paragraph, zip code employment data was obtained from the "U.S. Census Bureau, American Community Survey 2013-2017, Employment Status, Population 16 years and over," published by the Missouri Census Data Center. The applicable zip codes are listed in the table included herein;

7. For cultivation, manufacturing, and testing facilities, the score following any adjustments under paragraph 6. of this subsection is the final score;

8. For dispensary facilities, after evaluation criteria questions have been initially scored and adjusted as applicable under paragraph 6. of this subsection, and in order to facilitate patient access to medical marijuana, the rankings of dispensary facilities will be further adjusted by awarding additional points due to geographic location as follows:

A. First, the highest scoring dispensary facility in each of the one hundred sixty-three (163) Missouri House of Representatives districts as drawn and in effect on December 6, 2018, will receive an increase to its score pursuant to subparagraph C. of this paragraph, and all dispensary facility applicants' rankings will then be reordered. A map of the state of Missouri showing the applicable boundary lines of Missouri's house districts is available on the department's website;

B. Finally, any dispensary facility applicant with a location more than twenty-five (25) miles, measured in a straight line, from any other dispensary facility applicant or existing dispensary facility will receive an additional increase to its score pursuant to subparagraph C. of this paragraph, and all dispensary facility applicants' rankings will again be reordered. The resulting rank and score will be each dispensary facility's final rank and score;

C. Scoring increases due to geographic location will be equal to five percent (5%) of the average initial score of the top twenty-four (24) ranked facilities in each congressional district that has at least twenty-four (24) dispensary facility applicants; and

D. In cases where a house district is segmented by the boundary lines of two (2) or more congressional districts, for purposes of the adjustments in this paragraph, only the segment of that house district with the highest population, as of the 2010 United States Population Census, will be utilized; and

9. In the case of a tie for the last available license or certification in any category, the license or certification will go to—

A. The facility with the highest score in the topic specifically relating to that facility type;

B. If a tie remains, then the facility with the highest score in the business plan topic;

C. If a tie remains, then the facility with the highest score in the character topic;

D. If a tie remains, then the facility with the highest score in the site security topic;

E. If a tie remains, then the facility with the highest score in the economic impact topic;

F. If a tie remains, then the facility with the highest score in the legal cannabis market experience;

G. If a tie remains, then the facility will be chosen by lottery.

(D) Licenses and certifications will be issued as follows:

1. When the numerical scoring system is used, the highest

ranked facilities for each type of facility and, for dispensaries, in each congressional district, will receive licenses or certifications, except in cases where an entity under substantially common control, ownership, or management has applied for more than three (3) cultivation, three (3) manufacturing, or five (5) dispensary licenses. In those cases, the department will only issue licenses to the highest ranked facilities associated with that entity, up to the maximum number allowable in each category of license;

2. When the numerical scoring system is not used, all facilities that meet the minimum standards for licenses or certifications will be issued licenses or certifications, except in cases where an entity under substantially common control, ownership, or management has applied for more than five (5) dispensary licenses and some of those dispensaries are located in congressional districts that were numerically scored. In those cases, the department will first issue licenses to the dispensaries associated with that entity in congressional districts that were not numerically scored. Any remaining dispensaries associated with that entity will be issued licenses according to that dispensary's rank and score; and

3. All facilities that are issued a license or certification will be given forty-eight (48) hours to confirm they accept the license or certification. If a facility does not accept issuance of a license or certification, the license or certification will be offered to the next ranked facility, as applicable, until all available licenses and certifications are issued and accepted.

(5) The department will impose penalties as follows:

(A) For possessing marijuana in amounts between the possessor's legal limit and twice the possessor's legal limit, in addition to revocation of identification card(s) pursuant to 19 CSR 30-95.030(3)(B)1.D., the possessor will incur a penalty of two hundred dollars ($200);

(B) For failure to package medical marijuana consistent with 19 CSR 30-95.040(4)(K), a facility will incur a penalty of five thousand dollars ($5,000) for each category of improperly packaged product, and the improperly packaged medical marijuana will be recalled for repackaging or disposal, at the department's discretion; and

(C) Any person or facility that extracts resins from marijuana using combustible gases or other dangerous materials without a manufacturing facility license, shall incur a penalty.

1. In addition to revocation of identification cards pursuant to 19 CSR 30-95.030(3)(B)1.I., any patients or primary caregivers who extract resins in this manner will incur a penalty of one thousand dollars ($1000).

2. In addition to suspension of license, pursuant to 19 CSR 30-95.040(1)(F)7., facilities that extract resins in this manner will incur a penalty of ten thousand dollars ($10,000).

(7) Statewide Track and Trace System.

(A) No entity holding a contract with the state of Missouri for a statewide track and trace system or any affiliates of that entity may sell seed-to-sale tracking services or services related to compliance with seed-to-sale tracking regulations to a licensed or certified facility.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 95—Medical Marijuana

ORDER OF RULEMAKING

By the authority vested in the Division of Regulation and Licensure under Art. XIV Mo. Cont. the division adopts a rule as follows:

19 CSR 30-95.030 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2019 (44 MoReg 1886-1895). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received four (4) comments on the proposed rule, all from the DHSS Section for Medical Marijuana Regulation.

COMMENT #1: 19 CSR 30-95.030(3)(D)2. should be clarified as follows: ... However, the **later** authorization to cultivate will be added to the qualifying patient or primary caregiver identification card and will only remain valid as long as the qualifying patient or primary caregiver's identification card is still valid. **The cultivation application fee will be the same for all cultivation applications no matter how much time remains on the validity of the patient or caregiver's identification card. The cultivation authorization must be renewed at the time the patient or caregiver identification card is renewed.**

RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language clarifies the proposed rule. The existing rule already dictates that the cultivation authorization would run concurrently with the patient/caregiver authorization but did not address how the fee would be applied. It also did not specifically address the timing of renewals for cultivation authority that was added to an existing patient/caregiver authority. The rule is amended as suggested.

COMMENT #2: 19 CSR 30-95.030(4) should include a new provision stating: Non-emancipated qualifying patients are not eligible for patient cultivation authorization.

RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language complies with Section 1.7.(13) of Article XIV of the *Missouri Constitution*, which says, "Only the Qualifying Patient's parent or guardian shall purchase or possess medical marijuana for a non-emancipated Qualifying Patient under the age of eighteen." The rule is amended as suggested.

COMMENT #3: 19 CSR 30-95.030(4) should include a new provision stating: Only one individual in a patient-caregiver relationship may be authorized for patient cultivation.

RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language complies with Section 1.3.(2)(12) of Article XIV of the *Missouri Constitution*, which says, "a Qualifying Patient **or** his or her Primary caregiver may obtain an identification card from the department to cultivate up to six flowering marijuana plants for the exclusive use of that Qualifying Patient" (emphasis added). The rule is amended as suggested.

COMMENT #4: 19 CSR 30-95.030(8)(D) should be modified as follows: If medical marijuana in possession of a primary caregiver is stolen or lost, the primary caregiver must notify the department within two (2) days.

RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language clarifies the proposed rule. There is no department-approve format for this type of communication. The rule is amended as suggested.

19 CSR 30-95.030 Qualifying Patient/Primary Caregiver

(3) Application Processes.

(A) Upon receiving an application for a qualifying patient identification card, primary caregiver identification card, or patient cultivation identification card, the department shall, within thirty (30) days, either approve the application or provide a written explanation for its denial.

1. In the case of qualifying patient and patient cultivation identification cards, if the department fails to deny or fails to approve an application within thirty (30) days, a card will be issued that will be

valid for one (1) year and will serve all the same functions as would a card issued after application approval.

2. An application for a qualifying patient or patient cultivation identification card will be considered received when an application is submitted to the department that includes all information required by section (2) of this rule. The department will notify an applicant once if an application is incomplete and will specify in that notification what information is missing.

(B) Denial and revocation.

1. Qualifying patient, primary caregiver, and patient cultivation identification cards may be denied or revoked.

A. If an applicant provides false or misleading information in an application, the identification card for which the applicant is applying will be denied.

B. If an applicant fails to provide a complete application within ten (10) days of being notified that an application is incomplete, the identification card for which the applicant is applying will be denied.

(I) An applicant will be considered notified on the date the department sends a written explanation of how the application is incomplete to a mailing or e-mail address provided by the applicant.

(II) If an applicant fails to provide either a mailing or e-mail address, the department will not issue notice but will hold the application for thirty (30) days before denying it.

C. If a card holder violates any provision of this rule, any medical marijuana identification cards currently held by that individual may be revoked.

D. If a card holder is found to be in possession of an amount of marijuana greater than the medical marijuana legal limit applicable to that individual, any medical marijuana identification cards currently held by that individual will be revoked. In such a case, the identification card may be revoked for up to one (1) year.

E. If a card holder is convicted of, pleads guilty to, or receives a suspended imposition of sentence for a violation of section 579.020, 579.065, or 579.068, RSMo or for a violation of a similar law of another state, any medical marijuana identification cards currently held by that individual will be revoked. In such a case, the revocation shall be permanent, absent a gubernatorial pardon or expungement.

F. If an applicant has applied for a qualifying patient, primary caregiver, or qualifying patient cultivation identification card and received two (2) denials within a twelve- (12-) month period, has any of these types of identification cards revoked twice within a twenty-four- (24-) month period, or applied for any of these types of identification cards and been denied once and also had any of these types of identification cards revoked once within a twenty-four- (24-) month period, the identification card for which the applicant is applying will be denied.

G. If a patient cultivation identification card holder fails to immediately make available access to his or her patient cultivation facility upon request from the department, the patient cultivation identification card will be revoked.

H. If medical marijuana is stolen or lost, is identifiable as medical marijuana purchased by a particular qualifying patient or primary caregiver, is discovered in the possession of an individual who is not the qualifying patient or primary caregiver authorized to possess that medical marijuana, and was not timely reported as stolen or lost by the qualifying patient or primary caregiver authorized to possess that medical marijuana, the qualifying patient's or primary caregiver's identification card may be revoked.

I. If a qualifying patient or primary caregiver uses combustible gases or other dangerous materials to extract resins from marijuana, the qualifying patient's or primary caregiver's identification card may be revoked for up to one (1) year.

J. If the department determines there is good cause to do so, an application for a patient cultivation identification card may be denied.

2. Any denial or revocation shall be issued by the department in writing to the qualifying patient or, in the case of a primary caregiver, to the qualifying patient and the primary caregiver, and shall include the specific reasons for the denial or revocation and the process for requesting review of the department's decision.

(C) Renewal. Qualifying patient, primary caregiver, and patient cultivation identification cards are valid for twelve (12) months from their date of issuance and shall be renewable by submitting, prior to expiration by at least thirty (30) days but no sooner than sixty (60) days, a new or updated application, which shall include any information required by section (2) that has changed since the date of the previous application, including a new physician certification.

(D) The department shall charge a fee for medical marijuana identification card applications.

1. There will be a separate fee for each application to be a qualifying patient, each application to be a primary caregiver on behalf of a specific qualifying patient, and each application to cultivate medical marijuana on behalf of a specific qualifying patient.

2. Requests for authority to cultivate medical marijuana on behalf of a qualifying patient may be made within a qualifying patient or primary caregiver application or may be made separately at a later time. However, a later authorization to cultivate will be added to the qualifying patient or primary caregiver identification card and will only remain valid as long as the qualifying patient or primary caregiver's identification card is still valid. The cultivation application fee will be the same for all cultivation applications no matter how much time remains on the validity of the patient or caregiver's identification card. The cultivation authorization must be renewed at the time the patient or caregiver identification card is renewed.

3. Current fees, including any adjustments, will be posted on the department's website at http://medicalmarijuana.mo.gov.

(E) If the name or address of a qualifying patient or primary caregiver changes after an identification card is issued, the qualifying patient or primary caregiver shall notify the department within ten (10) days of the change.

(4) Qualifying Patient Cultivation.

(A) All qualifying patient cultivation shall take place in an enclosed, locked facility, as defined in 19 CSR 30-95.010.

(B) One (1) qualifying patient may cultivate up to six (6) flowering marijuana plants, six (6) nonflowering marijuana plants (over fourteen (14) inches tall), and six (6) clones (plants under fourteen (14) inches tall) at any given time in a single, enclosed locked facility. Two (2) qualifying patients, who both hold valid qualifying patient cultivation identification cards, may share one (1) enclosed, locked facility. No more than twelve (12) flowering marijuana plants, twelve (12) nonflowering plants, and twelve (12) clones may be cultivated in a single, enclosed locked facility, except when one (1) of the qualifying patients, as a primary caregiver, also holds a patient cultivation identification card for a third qualifying patient, in which case that primary caregiver may cultivate six (6) additional flowering marijuana plants, six (6) additional nonflowering marijuana plants, and six (6) additional clones for a total of eighteen (18) flowering marijuana plants, eighteen (18) nonflowering marijuana plants, and eighteen (18) clones in a single, enclosed locked facility.

(C) Under no circumstance will a qualifying patient be entitled to cultivate, or have cultivated on his or her behalf, more than six (6) flowering marijuana plants.

(D) Nothing in this section shall convey or establish a right to cultivate medical marijuana in a facility where state law or a private contract would otherwise prohibit doing so.

(E) All cultivated flowering marijuana plants in the possession of a qualifying patient or primary caregiver shall be clearly labeled with the qualifying patient's name.

(F) The department shall provide each qualifying patient or primary caregiver who receives a qualifying patient cultivation identification card with a cultivation authorization, which shall be clearly displayed within the enclosed cultivation area and in close proximity to

the marijuana plants. The authorization shall list the name of the qualifying patient or primary caregiver and the address of the facility in which that qualifying patient or primary caregiver is authorized to cultivate marijuana.

(G) Only one individual in a patient-caregiver relationship may be authorized for patient cultivation.

(H) Non-emancipated qualifying patients are not eligible for patient cultivation authorization.

(5) Purchase and Possession Limitations.

(A) Qualifying patients may only purchase, or have purchased on their behalf by their primary caregivers, four (4) ounces of dried, unprocessed marijuana per qualifying patient, or its equivalent, in a thirty- (30-) day period.

(B) Qualifying patients may only possess, or instruct a primary caregiver to possess on their behalf—

1. In the case of qualifying patients who do not cultivate or have medical marijuana cultivated on their behalf, up to a sixty- (60-) day supply of dried, unprocessed marijuana per qualifying patient, or its equivalent; or

2. In the case of qualifying patients who are cultivating marijuana for medical use or whose primary caregivers are cultivating marijuana on their behalf, up to a ninety- (90-) day supply of dried, unprocessed marijuana or its equivalent, so long as the supply of medical marijuana cultivated by the qualifying patients or primary caregivers remains on property under their control.

(C) All medical marijuana purchased from a dispensary must be stored in or with its original packaging.

(D) Primary caregivers may possess a separate legal limit for each qualifying patient under their care and a separate legal limit for themselves if they are a qualifying patient, each of which shall be stored separately for each qualifying patient and labeled with the qualifying patient's name.

(E) Purchase and possession limits established in this section shall not apply to a qualifying patient with written certification from two (2) independent physicians that there are compelling reasons why the qualifying patient needs a greater amount than the limits established in this section.

1. In such a case, both independent physicians must state in their certifications what amount the qualifying patient requires, which shall then be that patient's limit.

2. If the two (2) independent physicians disagree on what amount should be the patient's limit, the lower of the two (2) amounts shall be that patient's limit.

3. If the patient's limit is increased after receiving a qualifying patient identification card, the qualifying patient or primary caregiver shall notify the department within ten (10) days of the change.

(6) Non-Emancipated Qualifying Patient.

(A) A physician shall not issue a certification for the medical use of marijuana for a non-emancipated qualifying patient under the age of eighteen (18) without the written consent of a parent or legal guardian of the qualifying patient.

(B) The department shall not issue a qualifying patient identification card on behalf of a non-emancipated qualifying patient under the age of eighteen (18) without the written consent of a parent or legal guardian of the qualifying patient. Such card shall be issued to the parent or guardian and not directly to the patient.

(C) Only a parent or guardian may serve as a primary caregiver for a non-emancipated qualifying patient under the age of eighteen (18).

(D) Only the qualifying patient's parent or guardian who holds a primary caregiver identification card shall purchase or possess medical marijuana for a non-emancipated qualifying patient under the age of eighteen (18).

(E) A parent or guardian who holds a primary caregiver identification card shall supervise the administration of medical marijuana to a non-emancipated qualifying patient under the age of eighteen (18).

(7) Qualifying Patient Responsibilities.

(A) No qualifying patient shall consume marijuana for medical use in a public place, unless provided by law.

(B) No qualifying patient who is under the care of a primary caregiver may serve as the primary caregiver for another qualifying patient.

(C) If a qualifying patient is no longer entitled to medical marijuana or no longer wishes to hold a medical marijuana identification card, he or she must notify the department within ten (10) days of that change. The department will confirm in writing that the qualifying patient has voluntarily surrendered the identification card and that the identification card is no longer valid.

(D) If a qualifying patient's medical marijuana is stolen or lost, the qualifying patient must notify the department within two (2) days.

(8) Primary Caregiver Responsibilities.

(A) No individual shall serve as the primary caregiver for more than three (3) qualifying patients.

(B) No individual shall serve as a primary caregiver for a qualifying patient who is already served by two (2) primary caregivers.

(C) If a primary caregiver is no longer entitled to serve as a primary caregiver or no longer wishes to hold a primary caregiver identification card, he or she must notify the department within ten (10) days of that change. The department will confirm in writing that the primary caregiver has voluntarily surrendered the identification card and that the identification card is no longer valid.

(D) If medical marijuana in possession of a primary caregiver is stolen or lost, the primary caregiver must notify the department within two (2) days.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 95—Medical Marijuana

ORDER OF RULEMAKING

By the authority vested in the Division of Regulation and Licensure under Art. XIV Mo. Cont., the division adopts a rule as follows:

19 CSR 30-95.040 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2019 (44 MoReg 1896-1910). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received nine (9) comments on the proposed rule. Seven (7) comments were from the DHSS Section for Medical Marijuana Regulation, one was from Joseph D. Sheppard III, and one (1) was from Cassie Grewing.

COMMENT #1: DHSS states 19 CSR 30-95.040(1)(E) should be clarified to include the qualification that affiliates of the entity that currently holds a contract with the state are also subject to the prohibition.
RESPONSE: The suggested language is already included in the proposed rule. No change has been made to the proposed rule in response to this comment.

COMMENT #2: DHSS states 19 CSR 30-95.040(3)(E)6. should be modified to required that facility agents have a government-issued photo ID with them at all times in addition to their facility agent ID

cards.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language is reasonable. A government-issued photo ID card must be produced along with a facility agent ID card in order to verify the identity of the card holder. The rule is amended as suggested.

COMMENT #3: DHSS states 19 CSR 30-95.040(3)(E)7. should be clarified to ensure understanding that the fee for facility agent ID cards is an administration and processing fee and should increase or decrease with the Consumer Price Index.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language clarifies the nature of this fee and matches the adjustment mechanism used for other, similar fees established by Article XIV. The rule is amended as suggested.

COMMENT #4: Joseph Sheppard of Carnahan, Evans, Cantwell & Brown, P.C. states that in subparagraph 19 CSR 30-95.040(4)(C)3.D., the regulation requires the Department of Health's approval before any change in location of any licensed facility and only allows that approval if it is "no longer possible" to operate at the current location. There is no definition of what "no longer possible" or any provision that describes the circumstances. While MOCANNTRADE does not have an official position on this topic, several believe that this is too high a hurdle. Even with a market study and an economic impact study, the largest corporations in the country or in the world will still locate businesses in places that, for whatever reason, prove to be impractical or not optimal.

Suggested change: "Location may be changed with the consent of the Department of Health which shall balance the needs of the patients with the need of the licensee to maintain financial stability including factors such as (a) availability of medicine for the patient base in that geographical area; (b) adequacy of competition in the area; (c) safety and security of the patients and staff; (d) lack of demand in the community; (e) lack of supply (in the case of dispensaries) in another part of the state or congressional district; (f) conditions that make the licensee's current location unable to compete in the marketplace, among other factors, if material, to the decision. In addition, the location change request shall include support that claims made in the facility's initial licensure application regarding benefits the original location also apply to the facility's newly proposed location or a reasonable basis for a location change despite one or more of those benefits not applying to the new location."

Example: An area that once looked promising, due to changing demographics has caused significant challenges to maintain a sufficient patient base or a sufficient staffing level or both.

Alternative suggested change: Removal of the phrase 'no longer possible' such that D. would read 'an explanation for why the facility's original location is currently unduly burdensome for the licensee.'
RESPONSE AND EXPLANATION OF CHANGE: DHSS appreciates the thoughtfulness and thoroughness of this comment and agrees with many of the proposed standards for approving a change of location application. However, DHSS has not included such specificity in any of the other types of change approvals. This was an intentional policy decision in order to leave as much flexibility as possible for applicants to present and for DHSS to grant such applications. Also, DHSS is not convinced each standard in the suggested language would qualify as showing whether it is feasible to operate at an existing location, and some standards may make such a showing in one circumstance but not in others. Finally, the suggested language regarding a list of specific standards is not an exhaustive list and, as such, does not provide any more benefit to applicants or DHSS than would leaving the reasoning and approval up to the discretion of applicants and DHSS. However, DHSS does find the alternative suggestion is reasonable as a way to express a general standard without creating as high a bar for these approval requests. The rule is amended to reflect the alternative suggestion.

COMMENT #5: DHSS states 19 CSR 30-95.040(4)(C) should include a new provision to establish a fee for the extra approval processes facilities may seek for certain changes to their businesses. The new provision should say, "All requests for department approval described in this subsection must be accompanied by an administration and processing fee, due at the time of the request. This fee shall be two thousand dollars ($2000) on the effective date of this rule but shall increase or decrease each year by the percentage of increase or decrease from the end of the previous calendar year of the Consumer Price Index, or successor index as published by the U.S. Department of Labor, or its successor agency. The department shall publish the current fees, including any adjustments, on its website at http://medicalmarijuana.mo.gov."
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language is reasonable. The department approvals referenced in this new provision will require review and processing of requests that include much of the same volume and complexity as initial applications for licensure/certification. It is reasonable that an administration and processing fee should be associated with application for these department approvals. Furthermore, the amount of the fee is reasonable in that it is much less than the initial application fee, for comparatively similar review other than the cost of scoring an application. The rule is amended as suggested.

COMMENT #6: Cassie Grewing, on behalf of MOCANN Trade, states 19 CSR 30-95.040(4)(K)2.A.-B. reads (beginning in middle of pg. 1815):

(K) All cultivation, infused products manufacturing, and dispensary shall ensure that all medical marijuana is packaged and labeled in a manner consistent with the following:

1. Facilities shall not manufacture, package, or label marijuana—

A. In a false or misleading manner;

B. In any manner designed to cause confusion between a marijuana product and any product not containing marijuana; or

C. In any manner designed to appeal to a minor;

2. Marijuana and marijuana-infused products shall be sold in containers clearly and conspicuously labeled, in a font size at least as large as the largest other font size used on the package, with:

A. "Marijuana" or a "Marijuana-infused Product"; and

B. "Warning: Cognitive and physical impairment may result from the use of Marijuana"; See attached V3:

If possible, we would recommend considering a rule change during the feedback period to allow for the following before operators commit to packaging and labeling purchases after licenses are issued: "Marijuana and marijuana-infused products shall be sold in containers clearly and conspicuously labeled, in a font no smaller than 7 point type, with:"
RESPONSE AND EXPLANATION OF CHANGE: DHSS understands the concern. Unfortunately, part of the suggested language would be contrary to a provision of Article XIV of the *Missouri Constitution*, which says, "All marijuana and marijuana-infused products shall be sold in containers clearly and conspicuously labeled, in a font size at least as large as the largest other font size used on the package, as containing 'Marijuana,' or a 'Marijuana-infused Product.' Therefore, the department cannot make the suggested change to the part of the rule that repeats this requirement verbatim. However, the department can make the suggested change to the part of the rule regarding font size of the warning language and will do so. The rule is amended to reflect a change as described here.

COMMENT #7: DHSS states 19 CSR 30-95.040(5) should include a new provision following 19 CSR 30-95.040(5)(A)2., which should say, "The department may also request to interview an owner, officer, manager, contractor, employee, or other support staff of a licenses or certified facility, and the facility shall arrange for the interview to occur as soon as possible but not later than five (5) days after the department makes the request."

RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language is reasonable. The department authority for inspection should extend to discussing facility operations, etc., with the individuals performing, supervising, and directing those operations, and it should be the regulated entity's responsibility to facilitate that. The rule is amended as suggested.

COMMENT #8: DHSS states 19 CSR 30-95.040(5)(D) is duplicative of 19 CSR 30-95.025(3) and should be deleted.
RESPONSE AND EXPLANATION OF CHANGE: DHSS agrees. The rule is amended as suggested.

COMMENT #9: DHSS states the 19 CSR 30-95.040 authority section should cite to RSMo, 195.820.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggestion is reasonable. The newly passed section 195.820, RSMo is generally applicable to fees currently established by Article XIV and clarifies the department's authority for administrative fees that are not specifically established by Article XIV. The rule is amended as suggested.

19 CSR 30-95.040 Medical Marijuana Facilities Generally

(3) Facility Ownership and Employment.

(A) Cultivation, infused products manufacturing, dispensary, testing, and transportation facilities shall not be owned by, in whole or in part, or have as an officer, director, board member, manager, or employee, any individual with a disqualifying felony offense.

(B) Cultivation, infused products manufacturing, dispensary, testing, and transportation facilities shall be held by entities that are majority owned by natural persons who have been citizens of the state of Missouri for at least one (1) year prior to applying for a facility license or certification. For the purposes of this requirement, citizen means resident.

(C) No more than three (3) cultivation, no more than three (3) manufacturing, and no more than five (5) dispensary licenses shall be issued to any entity under substantially common control, ownership, or management. Any entity under substantially common control, ownership, or management that has applied for more than three (3) cultivation, three (3) manufacturing, or five (5) dispensary licenses shall contact the department at the time of application submission to identify for the department the applications associated with that entity. The department will use this information, once application scoring is complete pursuant to 19 CSR 30-95.025(4), solely for determining how many licenses the department may issue any particular entity.

(D) No testing facility shall be owned by an entity under substantially common control, ownership, or management as a cultivation, manufacturing, or dispensary facility.

(E) Facility Agent Identification Cards. Each owner, officer, manager, contractor, employee, and other support staff of a licensed or certified cultivation, dispensary, manufacturing, testing, or transportation facility shall obtain an agent identification card, which shall be assigned and display a unique, identifying number. For all such individuals associated with an entity at the time it is licensed or certified, any work they are performing for that entity may continue, but application for an agent identification card must be made within thirty (30) days of a license or certification being granted. For all other such individuals, applications for agent identification cards will be accepted only after an individual receives an offer of employment from a licensed or certified facility, and for those individuals, agent identification cards must be granted before they may begin employment with a licensed or certified entity.

1. All applications for agent identification cards and renewals of agent identification cards shall include at least the following information in a department-approved format:

A. Name, address, and Social Security number of the applicant;

B. A statement confirming that the applicant has submitted fingerprints within the previous six (6) months for a state and federal fingerprint-based criminal background check to be conducted by the Missouri State Highway Patrol;

C. A copy of a written offer of employment from a licensed or certified facility; and

D. All applicable fees.

2. Agent identification cards shall be valid for three (3) years.

3. If arrested for a disqualifying felony offense, agent identification card holders must notify the department within thirty (30) days of the arrest.

4. For purposes of this section, a contractor is a person or company that undertakes a contract with a licensed or certified facility to perform work that would include access to medical marijuana or related equipment or supplies for a time period greater than fourteen (14) days.

5. For purposes of this section, an owner is a person who holds any portion of the economic or voting interests of a facility and who will have access to medical marijuana or a medical marijuana facility.

6. Agent identification card holders must have their cards and a government-issued photo ID accessible to them at all times while performing work in or on behalf of a facility.

7. The department shall charge an administration and processing fee for identification cards, which shall be due at the time of application or renewal. This fee shall be seventy-five dollars ($75) on the effective date of this rule but shall increase or decrease each year by the percentage of increase or decrease from the end of the previous calendar year of the Consumer Price Index, or successor index as published by the U.S. Department of Labor, or its successor agency. The department shall publish the current fees, including any adjustments, on its website at http://medicalmarijuana.mo.gov.

(4) Facility Operation, Policies, and Procedures.

(A) Each cultivation, infused product manufacturing, or dispensary facility in operation must obtain a separate license, but multiple licenses may be utilized in a single facility. All licenses shall be displayed at all times within twenty feet (20') of the main entrance to a facility.

(B) Unless expressly allowed by the local government, no new cultivation, infused products manufacturing, dispensary, or testing facility shall be sited, at the time of application for license or for local zoning approval, whichever is earlier, within one thousand feet (1,000') of any then-existing elementary or secondary school, daycare, or church.

1. In the case of a freestanding facility, the distance between the facility and the school, daycare, or church shall be measured from the external wall of the facility structure closest in proximity to the school, daycare, or church to the closest point of the property line of the school, daycare, or church. If the school, daycare, or church is part of a larger structure, such as an office building or strip mall, the distance shall be measured to the entrance or exit of the school, daycare, or church closest in proximity to the facility.

2. In the case of a facility that is part of a larger structure, such as an office building or strip mall, the distance between the facility and the school, daycare, or church shall be measured from the property line of the school, daycare, or church to the facility's entrance or exit closest in proximity to the school, daycare, or church. If the school, daycare, or church is part of a larger structure, such as an office building or strip mall, the distance shall be measured to the entrance or exit of the school, daycare, or church closest in proximity to the facility.

3. Measurements shall be made along the shortest path between the demarcation points that can be lawfully traveled by foot.

(C) All licensed or certified cultivation, dispensary, manufacturing, testing, and transportation facilities must seek and obtain the department's approval before they may—

1. Assign, sell, give, lease, sublicense, or otherwise transfer its

license to any other entity.

A. If the entity to which the license or certification will be transferred is owned by the same entities as was the entity to which the department originally issued the license or certification, the request may be submitted after the facility at issue has been granted a license and must include at least the following:

(I) Legal name of the facility, including fictitious business names, and a certificate of good standing from the Missouri Secretary of State; and

(II) A completed Ownership Structure Form, included herein, which must show the applicant entity is owned by the same entities as was the entity to which the department originally issued the license or certification;

B. If the entity to which the license or certification will be transferred is not owned by the same entities as was the entity to which the department originally issued the license or certification, the request may be submitted beginning January 1, 2021, and shall include at least the same information required for an initial application for license or certification;

2. Make any changes to ten percent (10%) or more of the ownership interests of the facility. Such requests may be submitted after the facilities at issue have been granted a license and must include at least the following:

A. Name of each new owner, if any;

B. An updated Ownership Structure Form, included herein, which must show the applicant entity is majority owned by Missouri residents, and a written description or visual representation of the facility's ownership structure including all entities listed on the Ownership Structure Form;

C. For each owner claiming Missouri residency for purposes of subparagraph B of this paragraph, a statement that the owner has resided in Missouri for at least one (1) year and does not claim resident privileges in another state or country, as well as proof of current Missouri residency, which shall be shown by—

(I) A copy of a valid Missouri driver's license, a Missouri Identification Card, a current Missouri motor vehicle registration, or a recent Missouri utility bill; or

(II) If none of these proofs are available, some other evidence of residence in Missouri, which shall be approved or denied at the discretion of the director of the medical marijuana program as sufficient proof of residency;

D. A list of all facilities licensed or certified or applying for licensure or certification in Missouri to cultivate, manufacture, dispense, or test medical marijuana that are or will be under substantially common control, ownership, or management as the applicant. For each facility listed, an explanation of how the facility is under substantially common control, ownership, or management as the applicant, with supporting documentation;

E. An attestation that no individual who owns the facility, in whole or in part, has a disqualifying felony offense; and

F. A statement confirming that all owners who hold any portion of the economic or voting interest of a facility who will also have access to medical marijuana or a medical marijuana facility, and all officers, directors, board members, managers, and employees identified in the application have submitted fingerprints within the previous six months for a state and federal fingerprint-based criminal background check to be conducted by the Missouri State Highway Patrol;

3. Materially deviate from the proposed physical design or make material changes to the current physical design of the facility, including its location. Such requests may be submitted after the facilities at issue have been granted a license and shall include at least the following:

A. New or updated descriptions, schematics, or blueprints for the facility;

B. An attestation that the proposed changes to the facility comply with the facility location requirements of subsection (4)(B) of this rule or 19 CSR 30-95.100(2)(C) and any facility location requirements of the local government;

C. If the city, town, or county in which the facility will be located has enacted zoning restrictions applicable to the facility, the text of the restrictions and a description of how the changes to the facility comply with those restrictions; and

D. For location change requests, an explanation for why operating the facility at its original location is currently unduly burdensome for the licensee and proof that claims made in the facility's initial licensure application regarding benefits of its original location also apply to the facility's newly proposed location;

4. Combine licensed facilities at a single location. Such requests may be submitted after the facilities at issue have been granted a license and shall include at least the following:

A. Descriptions, schematics, or blueprints for the combined facilities;

B. An attestation that the proposed combination of facilities complies with the facility location requirements of subsection (4)(B) of this rule or 19 CSR 30-95.100(2)(C) and any location requirements of the local government;

C. If the city, town, or county in which the combined facilities will be located has enacted zoning restrictions applicable to the combined facilities, the text of the restrictions and a description of how the combined facilities will comply with those restrictions; and

D. If the combination of facilities is between two (2) or more entities with different ownership, documents showing the agreements between the entities concerning their respective roles and their relationship in regard to management, operation, and maintenance of the combined facility. Such agreements shall include an acknowledgment that all entities sharing management, operations, or maintenance of the combined facility shall be jointly responsible for compliance with the applicable department regulations for the shared spaces of the combined facility; or

5. Begin construction on a warehouse sited at a location other than the approved location of the facility. Such requests may be submitted after the facility at issue has been granted a license and shall include at least the following:

A. Descriptions, schematics, or blueprints for the warehouse;

B. An attestation that the proposed location for the warehouse complies with the facility location requirements of subsection (4)(B) of this rule or 19 CSR 30-95.100(2)(C) and any location requirements of the local government that would apply to the facility for which the warehouse is being constructed;

C. If the city, town, or county in which the warehouse will be located has enacted zoning restrictions applicable to the facility for which the warehouse is being constructed, the text of the restrictions and a description of how the warehouse will comply with those restrictions; and

D. An attestation that the warehouse will comply with all other rules applicable to the facility for which the warehouse is being constructed.

6. All requests for department approval described in this subsection must be accompanied by an administration and processing fee, due at the time of the request. This fee shall be two thousand dollars ($2000) on the effective date of this rule but shall increase or decrease each year by the percentage of increase or decrease from the end of the previous calendar year of the Consumer Price Index, or successor index as published by the U.S. Department of Labor, or its successor agency. The department shall publish the current fees, including any adjustments, on its website at http://medicalmarijuana.mo.gov

(D) All marijuana for medical use, including plants, flowers, and infused products, sold in Missouri shall be cultivated in a licensed cultivation facility located in Missouri. After December 31, 2020, marijuana for medical use shall be grown from seeds or plants obtained from a Missouri licensed cultivation or dispensary facility.

(E) Any excess or unusable medical marijuana or medical marijuana byproduct of a cultivation, manufacturing, dispensary, testing, or transportation facility shall be disposed of in the following manner, as applicable:

1. Solid and liquid wastes generated during medical marijuana production and processing must be stored, managed, and disposed of in accordance with applicable state, tribal, local, and municipal laws and regulations. Facilities must keep records of the final disposal destinations of all such wastes for at least five (5) years;

2. Wastewater generated during medical marijuana production and processing must be disposed of in compliance with applicable state, tribal, local, and municipal laws and regulations;

3. Wastes from the production and processing of medical marijuana plants must be evaluated against state hazardous waste regulations to determine if those wastes qualify as hazardous waste. It is the responsibility of each waste generator to properly evaluate their waste to determine if it is a hazardous waste per 40 CFR 262.11. If a generator's waste does qualify as a hazardous waste, then that waste is subject to the applicable hazardous waste management standards.

A. All solid waste, as defined by 40 CFR 261.2, must be evaluated under the hazardous waste regulations, including:

(I) Waste from medical marijuana flowers, trim, and solid plant material used to create an extract;

(II) Waste solvents, pesticides, and other similar materials used in the cultivation, manufacturing, or testing process;

(III) Discarded plant waste, spent solvents, and laboratory wastes from any medical marijuana processing or quality assurance testing; and

(IV) Medical marijuana extract that fails to meet quality testing.

B. Medical marijuana flowers, trim, and solid plant material are not in themselves considered hazardous waste unless they have been treated or contaminated with a hazardous waste constituent;

4. Medical marijuana waste that does not qualify as hazardous waste per 40 CFR 262.11 must be rendered unusable prior to leaving a facility, including plant waste, such as roots, stalks, leaves, and stems;

5. Medical marijuana plant waste that does not qualify as hazardous may be rendered unusable by grinding and incorporating the medical marijuana plant waste with other nonhazardous ground materials so the resulting mixture is at least fifty percent (50%) nonmarijuana waste by volume. Material used to grind with the medical marijuana may be either compostable waste or noncompostable waste. Other methods to render medical marijuana waste unusable must be approved by the department before implementation.

A. Compostable mixed waste: Medical marijuana waste to be disposed as compost feedstock or in another organic waste method (for example, anaerobic digester) may be mixed with the following types of waste materials:

(I) Food waste;

(II) Yard waste; or

(III) Vegetable based grease or oils.

B. Noncompostable mixed waste: Medical marijuana waste to be disposed in a landfill or another disposal method (for example, incinerator) may be mixed with the following types of waste materials:

(I) Paper waste;

(II) Cardboard waste;

(III) Plastic waste; or

(IV) Soil;

6. Medical marijuana waste that has been rendered unusable may be delivered to a permitted solid waste facility for final disposition. Examples of acceptable permitted solid waste facilities include:

A. For compostable mixed waste: Compost, anaerobic digester, or other facility with approval of the local health department; and

B. For noncompostable mixed waste: Landfill, incinerator, or other facility with approval of the local health department; or

7. All facility waste of any type must be stored securely before final disposition, which can be done within the facility in areas designated for disposal activities or, if necessary, outside the facility in a locked, tamper-resistant receptacle.

(F) All cultivation, manufacturing, dispensary, testing, and transportation facilities must establish and follow procedures to ensure medical marijuana remains free from contaminants. The procedures must address, at a minimum:

1. The flow through a facility of any equipment or supplies that will come in contact with medical marijuana including receipt and storage;

2. Employee health and sanitation;

3. Environmental factors, such as:

A. Floors, walls, and ceilings made of smooth, hard surfaces that are easily cleaned;

B. Temperature and humidity controls;

C. A system for monitoring environmental conditions;

D. A system for cleaning and sanitizing rooms and equipment;

E. A system for maintaining any equipment used to control sanitary conditions; and

F. For cultivation and manufacturing facilities, an air supply filtered through high-efficiency particulate air filters under positive pressure.

(G) All cultivation, infused products manufacturing, dispensary, testing, and transportation facilities shall implement inventory control systems and procedures as follows:

1. Each facility shall designate in writing a facility agent who is generally responsible for the inventory control systems and procedures for that facility;

2. All weighing and measuring of medical marijuana required by this rule must be conducted with a National Type Evaluation Program approved scale, which shall be capable of weighing and measuring accurately at all times and recalibrated at least yearly;

3. Each facility shall use a department-certified seed-to-sale tracking system to track medical marijuana from seed or immature plant stage until the medical marijuana is purchased by a qualifying patient or primary caregiver or destroyed. Records entered into the seed-to-sale tracking system must include each day's beginning inventory, harvests, acquisitions, sales, disbursements, remediations, disposals, transfers, ending inventory, and any other data necessary for inventory control records in the statewide track and trace system;

4. Each infused product manufacturing facility shall—

A. Establish and maintain a perpetual inventory system that documents the flow of materials through the manufacturing process;

B. Establish procedures to reconcile the raw material used to the finished product on the basis of each process lot. Significant variances must be documented, investigated by management personnel, and reported to the department and to the facility that ordered the infused product within twenty-four (24) hours of discovering the variances; and

C. Provide for quarterly physical inventory counts to be performed by facility employees who do not participate in the manufacturing process, which shall be reconciled to the perpetual inventory records. Significant variances must be documented, investigated by management personnel, and reported to the department within twenty-four (24) hours of discovering the variances;

5. Each dispensary facility shall be responsible for ensuring that every amount of medical marijuana sold or disbursed to a qualifying patient or primary caregiver is recorded in the seed-to-sale tracking system as a purchase by or on behalf of the applicable qualifying patient. Amounts of medical marijuana shall be recorded—

A. For dried, unprocessed marijuana, in ounces or grams;

B. For concentrates, in grams; or

C. For infused products, by milligrams of THC;

6. If a facility identifies a reduction in the amount of medical marijuana in the inventory of the facility, the facility must document where in the facility's processes the loss has occurred, if possible, and take and document corrective action. If the reduction in the amount of medical marijuana in the inventory of the facility is due to suspected criminal activity by a facility agent, the facility shall report the facility agent to the department and to the appropriate law

enforcement agencies within twenty-four (24) hours of discovering the suspected criminal activity;

7. A medical marijuana facility shall maintain all records required by this subsection for at least five (5) years; and

8. In case of seed-to-sale system failure or loss of connection to the statewide track and trace system, the facility may continue performing for up to five (5) hours all actions that are required to be tracked, except sales of medical marijuana or transfers of medical marijuana from the facility, as long as the facility records all necessary tracking information and enters that information into its seed-to-sale tracking system upon restoration of the system or into the statewide track and trace system upon restoration of the connection.

(H) All cultivation, infused products manufacturing, and dispensary facilities shall ensure the security of medical marijuana and facility employees by taking at least the following measures:

1. Facilities shall install and maintain security equipment designed to prevent unauthorized entrance into limited access areas and to prevent diversion and inversion of medical marijuana including:

A. Devices or a series of devices to detect unauthorized intrusion, which may include a signal system interconnected with a radio frequency method, such as cellular or private radio signals, or other mechanical or electronic devices;

B. Except in the case of outdoor cultivation, exterior lighting to facilitate surveillance, which shall cover the exterior and perimeter of the facility;

C. Electronic video monitoring, including:

(I) At least one (1) call-up monitor that is nineteen inches (19") or more;

(II) A printer capable of immediately producing a clear still photo from any video camera image;

(III) Video cameras with a recording resolution of at least 1920 x 1080, or the equivalent, at a rate of at least fifteen (15) frames per second, that operate in such a way as to allow identification of people and activities in the monitored space, in all lighting levels, that are capable of being accessed remotely by the department or a law enforcement agency in real time upon request, and that provide coverage of—

(a) All entrances and exits of the facility, including windows, and all entrances and exits from limited access areas;

(b) The perimeter and exterior areas of the facility, including at least twenty feet (20') of space around the perimeter of an outdoor grow area;

(c) Each point-of-sale location;

(d) All vaults or safes; and

(e) All medical marijuana, from at least two (2) angles, where it is cultivated, cured, trimmed, processed, rendered unusable, and disposed;

(IV) A method for storing recordings from the video cameras for at least sixty (60) days in a secure on-site or off-site location or through a service or network that provides on-demand access to the recordings and that allows for providing copies of the recordings to the department upon request and at the expense of the facility;

(V) A failure notification system that provides an audible and visual notification of any failure in the electronic monitoring system; and

(VI) Sufficient battery backup for video cameras and recording equipment to support at least sixty (60) minutes of recording in the event of a power outage;

D. Controlled entry to limited access areas, which shall be controlled by electronic card access systems, biometric identification systems, or other equivalent means, except that, in addition to these means, all external access doors shall be equipped with a locking mechanism that may be used in case of power failure. Access information shall be recorded, and all records of entry shall be maintained for at least one (1) year;

E. A method of immediate, automatic notification to alert local law enforcement agencies of an unauthorized breach of security at the facility; and

F. Manual, silent alarms at each point-of-sale, reception area, vault, and electronic monitoring station with capability of alerting local law enforcement agencies immediately of an unauthorized breach of security at the facility;

2. Facilities shall establish policies and procedures—

A. For restricting access to the areas of the facility that contain medical marijuana to only persons authorized to be in those areas, which shall include, when necessary for business purposes, contractors hired for no more than fourteen (14) days and other visitors, all of which may enter the restricted area if they sign in and sign out of a visitor log and are escorted at all times by facility agents in a ratio of no less than one (1) facility agent per five (5) visitors;

B. For identifying persons authorized to be in the areas of the facility that contain medical marijuana;

C. For identifying facility agents responsible for inventory control activities;

D. For limiting the amount of money available in any retail areas of the facility and for notifying the public that there is a minimal amount of money available, including by posting of a sign;

E. For electronic monitoring;

F. For the use of the automatic or electronic notification and manual, silent alarms to alert local law enforcement agencies of an unauthorized breach of security at the facility, including designation of on-call facility personnel to respond to, and to be available to law enforcement personnel who respond to, any alarms; and

G. For keeping local law enforcement updated on whether the facility employs armed security personnel and how law enforcement can identify such personnel on sight;

3. Facilities with outdoor cultivation shall construct an exterior barrier around the perimeter of the marijuana cultivation area that consists of a fence that is—

A. Constructed of six (6) gauge metal or stronger chain link;

B. Topped with razor wire or similar security wire;

C. At least eight feet (8') in height; and

D. Screened such that the cultivation area is not easily viewed from outside the fence;

4. Facilities with windows in a limited access area must ensure either that the window cannot be opened and is designed to prevent intrusion or that the window is otherwise inaccessible from the outside;

5. Facilities shall ensure that each video camera used pursuant to this section—

A. Includes a date and time generator which possesses the capability to accurately display the date and time of recorded events on the recording in a manner that does not significantly obstruct the recorded view; and

B. Is installed in a manner that will prevent the video camera from being readily obstructed, tampered with, or disabled;

6. A facility shall make a reasonable effort to repair any malfunction of security equipment within seventy-two (72) hours after the malfunction is discovered. A facility shall notify the department within twenty-four (24) hours after a malfunction is discovered and provide a plan of correction.

A. If a video camera used pursuant this section malfunctions, the facility shall immediately provide alternative video camera coverage or use other security measures until video camera coverage can be restored, such as assigning additional supervisory or security personnel, to provide for the security of the facility. If the facility uses other security measures, the facility must immediately notify the department, and the department will determine whether the other security measures are adequate and for what amount of time those other security measures will be acceptable.

B. Each facility shall maintain a log that documents each malfunction and repair of the security equipment of the facility. The log must state the date, time, and nature of each malfunction; the efforts taken to repair the malfunction and the date of each effort; the reason for any delay in repairing the malfunction; the date the malfunction

is repaired and; if applicable, any alternative security measures that were taken. The log must also list, by date and time, all communications with the department concerning each malfunction and corrective action. The facility shall maintain the log for at least one (1) year after the date of last entry in the log;

7. Each facility shall employ a security manager who shall be responsible for—

A. Conducting a semiannual audit of security measures to ensure compliance with this subsection and to identify potential security issues;

B. Training employees on security measures, emergency response, and theft prevention and response within one (1) week of hiring and on an annual basis;

C. Evaluating the credentials of any contractors who intend to provide services to the facility before the contractor is hired by or enters into a contract with the facility; and

D. Evaluating the credentials of any third party who intends to provide security to the facility before the third party is hired by or enters into a contract with the facility; and

8. Each facility shall ensure that the security manager of the facility, any facility agents who provide security for the facility, and the employees of any third party who provides security to the facility have completed the following training:

A. Training in theft prevention or a related subject;

B. Training in emergency response or a related subject;

C. Training in the appropriate use of force or a related subject that covers when the use of force is and is not necessary;

D. Training in the protection of a crime scene or a related subject;

E. Training in the control of access to protected areas of a facility or a related subject;

F. Not less than eight (8) hours of training at the facility in providing security services; and

G. Not less than eight (8) hours of classroom training in providing security services.

(I) The department may issue public notice of a medical marijuana recall if, in its judgment, any particular medical marijuana presents a threat to the health and safety of qualifying patients. All facilities are responsible for complying with recall notices. Recalled items must be immediately pulled from production or inventory and held until such time as the department determines the item is safe, may be remediated, or must be destroyed.

(J) Medical marijuana that fails testing or is subject to a recall must either be destroyed by any facility in possession of that medical marijuana or, at the election of the facility from which the failed test or recalled item originated, and with approval of the department, may be remediated, if possible.

1. Remediated medical marijuana must pass all testing required by 19 CSR 30-95.070;

2. Facilities may only elect to remediate any particular medical marijuana once.

(K) All cultivation, infused products manufacturing, and dispensary facilities shall ensure that all medical marijuana is packaged and labeled in a manner consistent with the following:

1. Facilities shall not manufacture, package, or label marijuana—

A. In a false or misleading manner;

B. In any manner designed to cause confusion between a marijuana product and any product not containing marijuana; or

C. In any manner designed to appeal to a minor;

2. Marijuana and marijuana-infused products shall be sold in containers clearly and conspicuously labeled with:

A. "Marijuana" or a "Marijuana-infused Product" in a font size at least as large as the largest other font size used on the package; and

B. "Warning: Cognitive and physical impairment may result from the use of Marijuana" in a font no smaller than seven- (7-) point type;

3. Any marijuana or marijuana-infused products packaged for retail sale before delivery to a dispensary must be packaged in opaque, re-sealable packaging designed or constructed to be significantly difficult for children under five (5) years of age to open but not normally difficult for adults to use properly. Any marijuana or marijuana-infused products not packaged for retail sale before delivery to a dispensary must be packaged by the dispensary upon sale to a qualifying patient or primary caregiver in opaque, re-sealable packaging designed or constructed to be significantly difficult for children under five (5) years of age to open but not normally difficult for adults to use properly. All edible marijuana-infused products must be packaged for retail by the infused-products manufacturer before transfer to a dispensary;

4. Marijuana and marijuana-infused products shall bear a label displaying the following information, in the following order:

A. The total weight of the marijuana included in the package:

(I) For dried, unprocessed marijuana, weight shall be listed in ounces or grams;

(II) For concentrates, weight shall be listed in grams; or

(III) For infused products, weight shall be listed by milligrams of THC;

B. Dosage amounts, instructions for use, and estimated length of time the dosage will have an effect;

C. The THC, tetrahydrocannabinol acid, cannabidiol, cannabidiol acid, and cannabinol concentration per dosage;

D. All active and inactive ingredients, which shall not include groupings of ingredients that obscure the actual ingredients, such as "proprietary blend" or "spices";

E. In the case of dried, unprocessed marijuana, the name, as recorded with the Missouri Secretary of State, of the cultivating facility from which the marijuana in the package originated and, in the case of infused products, the name of the infused-product manufacturer, as recorded with the Missouri Secretary of State; and

F. A "best if used by" date;

5. No branding, artwork, or other information or design elements included on marijuana or marijuana-infused products shall be placed in such a way as to obscure any of the information required by this section;

6. Marijuana and marijuana-infused product packaging shall not include claims of health benefits but may include health warnings; and

7. Marijuana and marijuana-infused products must, at all times, be tagged with traceability information generated by the statewide track and trace system.

(L) Cultivation, manufacturing, dispensary, and testing facilities that transport medical marijuana must also comply with 19 CSR 30-95.100(D) in doing so.

(M) Signage and advertising on facility premises must comply with the following:

1. A facility may not display marijuana, marijuana paraphernalia, or advertisements for these items in a way that is visible to the general public from a public right-of-way; and

2. Outdoor signage and, if visible to the public, interior signage, must comply with any local ordinances for signs or advertising and—

A. May not display any text other than the facility's business name or trade name, address, phone number, and website; and

B. May not utilize images or visual representations of marijuana plants, products, or paraphernalia, including representations that indicate the presence of these items, such as smoke.

(5) Facility Inspections.

(A) Submission of an application for a facility license or certification constitutes consent to inspection by the department. A department inspector conducting an inspection pursuant to this section need not give prior notice of the inspection and, during the inspection, must be given access to all areas and property of the facility, including vehicles, wherever located, without delay.

1. The department will enter and inspect at least annually, with

or without notice, to ensure compliance with this chapter.

2. The department may also, at any time it determines an inspection is needed, conduct an inspection, including an inspection of any part of the premises, qualifications of personnel, methods of operation, records, and policies and procedures of a licensed or certified facility.

3. The department may also request to interview an owner, officer, manager, contractor, employee, or other support staff of a licensed or certified facility, and the facility shall arrange for the interview to occur as soon as possible but not later than five (5) days after the department makes the request.

(B) Once a licensed or certified facility believes it will, within a month, be ready to begin operations and meet all state and local requirements for its facility, it shall request that the department conduct a commencement inspection to confirm the facility is in compliance with all requirements of this chapter.

(C) Violations, Compliance Verification Inspections, and Suspension.

1. If the department determines, during an inspection or otherwise, that a facility is not in compliance with the department's regulations, the department will issue an Initial Notice of Violation to the facility that explains how the facility has violated the department's regulations and what remedial actions the department expects the facility to take to correct the violations.

2. Once a facility has been notified of violations, the facility shall correct the violations within fifteen (15) days, and the department will conduct a follow-up inspection within fifteen (15) to thirty (30) days to confirm the facility has corrected the violations. The facility shall notify the department if it believes it needs additional time to correct the violations, which the department may grant for good cause.

3. If the department's follow-up inspection reveals the violations have not been corrected, the department will issue a Final Notice of Violation to the facility explaining how the facility continues to violate the department's regulations, what remedial actions the department expects the facility to take, and notifying the facility that its license or certifications will be suspended if the specified remedial action is not taken and the violations corrected within thirty (30) days.

4. If the violations have not been corrected thirty (30) days after a Final Notice of Violation and no extension of this deadline has been granted by the department, the facility's license or certification will be suspended, the facility will be required to cease operations, and the facility must sign a corrective action plan designed to bring the facility into compliance.

(D) If, at any time, the department determines a facility presents an immediate and serious threat to the health and safety of the public or of the facility's employees, the department may order the facility to immediately suspend all or a part of its operations until the threat has been eliminated.

AUTHORITY: sections 1.3.(1)(b) and 1.3.(2) of Article XIV, Mo. Const. and section 195.820, RSMo Supp. 2019. Emergency rule filed May 24, 2019, effective June 3, 2019, expires Feb. 27, 2020. Original rule filed May 24, 2019.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 95—Medical Marijuana

ORDER OF RULEMAKING

By the authority vested in the Division of Regulation and Licensure under Art. XIV Mo. Cont., the division adopts a rule as follows:

19 CSR 30-95.050 Cultivation Facility **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2019 (44 MoReg 1911-1913). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 95—Medical Marijuana

ORDER OF RULEMAKING

By the authority vested in the Division of Regulation and Licensure under Art. XIV Mo. Cont., the division adopts a rule as follows:

19 CSR 30-95.060 Infused Products Manufacturing Facility **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2019 (44 MoReg 1914-1916). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 95—Medical Marijuana

ORDER OF RULEMAKING

By the authority vested in the Division of Regulation and Licensure under Art. XIV Mo. Cont., the division adopts a rule as follows:

19 CSR 30-95.070 Testing Facility **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2019 (44 MoReg 1917-1921). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 95—Medical Marijuana

ORDER OF RULEMAKING

By the authority vested in the Division of Regulation and Licensure under Art. XIV Mo. Cont., the division adopts a rule as follows:

19 CSR 30-95.080 Dispensary Facility **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2019 (44 MoReg 1922-1925). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 95—Medical Marijuana

ORDER OF RULEMAKING

By the authority vested in the Division of Regulation and Licensure under Art. XIV Mo. Cont., the division adopts a rule as follows:

19 CSR 30-95.090 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2019 (44 MoReg 1926-1930). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received three (3) comments on the proposed rule, all from the DHSS Section for Medical Marijuana Regulation.

COMMENT #1: 19 CSR 30-95.090(3)(A) contains a typo. The citation referenced should be 19 CSR 30-95.080(2)(C), not 19 CSR 30-95.080(2)(D).
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the comment is accurate. The rule is amended as suggested.

COMMENT #2: 19 CSR 30-95.090(4)(A) should be rephrased as a prohibition since it appears in a section of prohibitions.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language clarifies the proposed rule. The rule is amended as suggested.

COMMENT #3: 19 CSR 30-95.090(4)(B) should be clarified to include the qualification that affiliates of the entity that currently holds a contract with the state are also subject to the prohibition.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language is appropriate. The word "currently" makes the provision ambiguous since it is not clear what time period should be considered current. The rule is amended as suggested.

19 CSR 30-95.090 Seed-to-Sale Tracking

(3) Seed-to-Sale Tracking System Requirements. All seed-to-sale tracking systems used by cultivation, manufacturing, dispensary, testing, and transportation facilities shall be capable of—

(A) Interfacing with the statewide track and trace system such that a licensed or certificated facility may enter and access information in the statewide track and trace system as required for inventory control and tracking by 19 CSR 30-95.040(4)(G) and for purchase limitations by 19 CSR 30-95.080(2)(C);

(B) Providing the department with access to all information stored in the system's database;

(C) Maintaining the confidentiality of all patient data and records accessed or stored by the system such that all persons or entities other than the department may only access the information in the system that they are authorized by law to access; and

(D) Producing analytical reports to the department regarding—

1. Total quantity of daily, monthly, and yearly sales at the facility per product type;

2. Average prices of daily, monthly, and yearly sales at the facility per product type; and

3. Total inventory or sales record adjustments at the facility.

(4) Seed-to-Sale Tracking System Prohibitions.

(A) No certified seed-to-sale tracking system entities may begin operations before signing the department's Medical Marijuana Application Programming Interface User Agreement.

(B) No seed-to-sale tracking system entity may sell seed-to-sale tracking services or services related to compliance with seed-to-sale tracking regulations to a licensed or certified facility if it is owned by or affiliated with an entity that holds a contract with the state of Missouri for any product or service related to the department's medical marijuana program.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 95—Medical Marijuana

ORDER OF RULEMAKING

By the authority vested in the Division of Regulation and Licensure under Art. XIV Mo. Cont., the division adopts a rule as follows:

19 CSR 30-95.100 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2019 (44 MoReg 1931-1932). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received two (2) comments on the proposed rule, both from the DHSS Section for Medical Marijuana Regulation.

COMMENT #1: 19 CSR 30-95.100(2)(B) should be clarified to say that all transportation of medical marijuana should occur between an originating facility and a destination, not a destination facility, within twenty-four (24) hours.
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested language clarifies the proposed rule. Transportation facilities can transport to more locations than just other facilities. The rule is amended as suggested.

COMMENT #2: 19 CSR 30-95.100(2)(C) should be replaced with the location requirements applicable to all other facility types, which can be found at 19 CSR 30-95.040(4)(B).
RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggested change is appropriate. All medical marijuana facilities should be held to the same standard on this constitutional requirement. The rule is amended as suggested.

19 CSR 30-95.100 Transportation Facility

(2) Transportation Facility Requirements. In addition to the requirements for transportation facilities in 19 CSR 30-95.040, transportation facilities shall also comply with the provisions of this section.

(A) Transportation facilities must ensure all facility employees are trained in at least the following:

1. The use of security measures and controls that have been adopted by the facility for the prevention of diversion, inversion,

theft, or loss of medical marijuana;

2. Proper use of the statewide track and trace system;

3. Procedures for responding to an emergency, including severe weather, fire, natural disasters, and unauthorized intrusions; and

4. Standards for maintaining the confidentiality of information related to the medical use of marijuana, including, but not limited to, compliance with the Health Insurance Portability and Accountability Act of 1996.

(B) Transportation facilities shall transport all medical marijuana from an originating facility to a destination within twenty-four (24) hours. When extenuating circumstances necessitate holding medical marijuana longer than twenty-four (24) hours, the transportation facility shall notify the department of the circumstances and the location of the medical marijuana.

(C) Unless expressly allowed by the local government, no new transportation facility shall be sited, at the time of application for certification or for local zoning approval, whichever is earlier, within one thousand feet (1,000') of any then-existing elementary or secondary school, daycare, or church.

1. In the case of a freestanding facility, the distance between the facility and the school, daycare, or church shall be measured from the external wall of the facility structure closest in proximity to the school, daycare, or church to the closest point of the property line of the school, daycare, or church. If the school, daycare, or church is part of a larger structure, such as an office building or strip mall, the distance shall be measured to the entrance or exit of the school, daycare, or church closest in proximity to the facility.

2. In the case of a facility that is part of a larger structure, such as an office building or strip mall, the distance between the facility and the school, daycare, or church shall be measured from the property line of the school, daycare, or church to the facility's entrance or exit closest in proximity to the school, daycare, or church. If the school, daycare, or church is part of a larger structure, such as an office building or strip mall, the distance shall be measured to the entrance or exit of the school, daycare, or church closest in proximity to the facility.

3. Measurements shall be made along the shortest path between the demarcation points that can be lawfully traveled by foot.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 95—Medical Marijuana

ORDER OF RULEMAKING

By the authority vested in the Division of Regulation and Licensure under Art. XIV Mo. Cont., the division adopts a rule as follows:

19 CSR 30-95.110 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2019 (44 MoReg 1933-1935). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received one (1) comment on the proposed rule from the DHSS Section for Medical Marijuana Regulation.

COMMENT #1: 19 CSR 30-95.110 should include a new provision, which should say, "The department may request to interview any physician who chooses to certify individuals as qualifying patients. If such a request is made, the physician shall arrange for the interview to occur as soon as possible but not later than thirty (30) days after the department makes the request."

RESPONSE AND EXPLANATION OF CHANGE: DHSS finds the suggestion is reasonable. The department's oversight of patient applications for authorization to access medical marijuana should extend to interviewing the physician that certified a patient, which is the foundation for the patient's application. For example: If there is reason to believe a patient has modified a physician's certification, DHSS should have the ability to interview the physician to verify whether the certification remains as the physician entered it. Furthermore, the suggested language serves the interest of transparency in that it gives physicians notice of DHSS' expectation that such conversations may be necessary. The rule is amended as suggested.

19 CSR 30-95.110 Physicians

(2) The department may request to interview any physician who chooses to certify individuals as qualifying patients. If such a request is made, the physician shall arrange for the interview to occur as soon as possible but no later than thirty (30) days after the department makes the request.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

NOTIFICATION OF REVIEW: APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the CON applications listed below. A decision is tentatively scheduled for December 24, 2019. These applications are available for public inspection at the address shown below.

Date Filed

Project Number: Project Name
City (County)
Cost, Description

11/08/2019

#5747 HT: Barnes-Jewish Hospital
St. Louis (St. Louis City)
$3,500,000, Replace radiation therapy system/linear accelerator

11/12/2019

#5741 RT: Mother of Perpetual Help
Shrewsbury (St. Louis County)
$4,513,637, Ren/Mod existing 160-bed ALF

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by December 13, 2019. All written requests and comments should be sent to—

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
3418 Knipp Drive, Suite F
PO Box 570
Jefferson City, MO 65102
For additional information contact Alison Dorge at alison.dorge@health.mo.gov.

The Secretary of State is required by sections 347.141 and 359.481, RSMo, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to adrules.dissolutions@sos.mo.gov.

Notice of Dissolution to All Creditors of and All Claimants Against Saint Louis Heart Association

On October 15, 2019, Saint Louis Heart Association, a Missouri nonprofit corporation (the "Company"), filed its Articles of Dissolution by Voluntary Action with the Missouri Secretary of State.

Any claims against the Company must be sent to: Thomas J. Minogue, c/o Thompson Coburn LLP, One U.S. Bank Plaza, Suite 3400, St. Louis, Missouri 63101. Each claim must include the name, address and phone number of claimant; amount and nature of claim; date on which the claim arose; and any claim documentation.

All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the date of publication of this notice.

NOTICE OF DISSOLUTION TO ALL CREDITORS AND CLAIMANTS AGAINST GLADSTONE DENTAL GROUP, INC.

On August 5, 2019, Gladstone Dental Group, Inc., a Missouri Corporation, filed its Articles of Dissolution with the Missouri Secretary of State. The dissolution was effective on September 30, 2019.

You are hereby notified that if you believe you have a claim against Gladstone Dental Group, Inc., you must submit a summary in writing of the circumstances surrounding your claim to the corporation c/o Larry G. Schulz, of Sexton, Bender, Hill & Steinman, P.C., 2900 Brooktree Lane, Suite 100, Gladstone, Missouri 64119. The summary of your claim must include the following information:

1. The name, address and telephone number of the claimant.
2. The date of the event on which the claim is based.
3. A brief description of the nature of the debt and amount of the claim.

All claims against Gladstone Dental Group, Inc. will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the date of this publication.

NOTICE OF WINDING UP TO ALL CREDITORS AND CLAIMANTS AGAINST BAKER FAMILY INVESTMENTS, LLC

Baker Family Investments LLC, a Missouri limited liability company, filed its notice of Winding Up for Limited Liability Company with the Missouri Secretary of State on May 28, 2019. Any and all claims against Baker Family Investments LLC may be sent to Dan A. Baker, 2605 Anderson Avenue, Sedalia, MO 65301. Each claim should include the following information: the name, address, and telephone number of the claimant; the amount of the claim; the basis of the claim; and the date(s) on which the event(s) on which the claim is based occurred.

Any and all claims against Baker Family Investments LLC will be barred unless a proceeding to enforce such claim is commenced with three years after the date this notice is published.

NOTICE OF WINDING UP AND DISSOLUTION TO ALL CREDITORS AND CLAIMANTS AGAINST GUMBO REAL ESTATE, L.L.C.

GUMBO REAL ESTATE, L.L.C., a Missouri limited liability company, plans to dissolve and has filed a Notice of Winding Up with the Missouri Secretary of State on September 13, 2019. Any and all claims against GUMBO REAL ESTATE, L.L.C. should be forwarded to James M. Schloeman, 544 Conway Village Drive, St. Louis, Missouri 63141. Each claim should include the following: (i) the name, address and telephone number of the claimant; (ii) the amount of the claim; (iii) the basis for the claim; and (iv) documentation of the claim. Any claims against GUMBO REAL ESTATE, L.L.C. will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

NOTICE OF WINDING UP AND DISSOLUTION TO ALL CREDITORS AND CLAIMANTS AGAINST GUMBO REAL ESTATE II, L.L.C.

GUMBO REAL ESTATE II, L.L.C., a Missouri limited liability company, plans to dissolve and has filed a Notice of Winding Up with the Missouri Secretary of State on September 13, 2019. Any and all claims against GUMBO REAL ESTATE II, L.L.C. should be forwarded to James M. Schloeman, 544 Conway Village Drive, St. Louis, Missouri 63141. Each claim should include the following: (i) the name, address and telephone number of the claimant; (ii) the amount of the claim; (iii) the basis for the claim; and (iv) documentation of the claim. Any claims against GUMBO REAL ESTATE II, L.L.C. will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

NOTICE OF CORPORATE DISSOLUTION TO ALL CREDITORS AND CLAIMANTS OF HORSTMEYER ENTERPRISES, INC.

You are hereby notified that HORSTMEYER ENTERPRISES, INC., a Missouri corporation, the principal office of which is located at 4313 Gulfstream Parkway, Cape Coral, FL 33993, (the "Corporation") filed Articles of Dissolution with the Secretary of the State of Missouri on October 22, 2019. In order to file a claim with the Corporation, you must furnish:

1. The name and address of the claimant;
2. Amount of claim;
3. Basis for the claim;
4. Documentation of the claim; and
5. The date(s) on which the event(s) on which the claim is based occurred.

The claim must be mailed to Wm. Randolph Weber, 200 North Third Street, St. Charles, Missouri 63301. A claim against the Corporation will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication date of this notice.

NOTICE OF CORPORATE DISSOLUTION TO ALL CREDITORS AND CLAIMANTS OF REBAR INSTALLATION, INC.

You are hereby notified that REBAR INSTALLATION, INC., a Missouri corporation, the principal office of which is located at 4313 Gulfstream Parkway, Cape Coral, FL 33993, (the "Corporation") filed Articles of Dissolution with the Secretary of the State of Missouri on October 22, 2019. In order to file a claim with the Corporation, you must furnish:

1. The name and address of the claimant;
2. Amount of claim;
3. Basis for the claim;
4. Documentation of the claim; and
5. The date(s) on which the event(s) on which the claim is based occurred.

The claim must be mailed to Wm. Randolph Weber, 200 North Third Street, St. Charles, Missouri 63301. A claim against the Corporation will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication date of this notice.

NOTICE OF CORPORATE DISSOLUTION TO ALL CREDITORS AND CLAIMANTS OF MDM HOLDING COMPANY

You are hereby notified that MDM HOLDING COMPANY, a Missouri corporation, the principal office of which is located at 4313 Gulfstream Parkway, Cape Coral, FL 33993, (the "Corporation") filed Articles of Dissolution by Voluntary Action with the Secretary of the State of Missouri on October 22, 2019. In order to file a claim with the Corporation, you must furnish:

1. The name and address of the claimant;
2. Amount of claim;
3. Basis for the claim;
4. Documentation of the claim; and
5. The date(s) on which the event(s) on which the claim is based occurred.

The claim must be mailed to Wm. Randolph Weber, 200 North Third Street, St. Charles, Missouri 63301. A claim against the Corporation will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication date of this notice.

NOTICE OF DISSOLUTION OF CORPORATION
TO ALL CREDITORS OF AND CLAIMANTS AGAINST
HEARTLAND CANCER CENTER INC

On October 22, 2019, **HEARTLAND CANCER CENTER INC,** a Missouri corporation, filed Articles of Dissolution by Voluntary Action with the Missouri Secretary of State. You are hereby notified that if you believe you have a claim against **HEARTLAND CANCER CENTER INC,** you must submit a summary in writing of the circumstances surrounding your claim to: Daniel M. Runion, SHAFFER LOMBARDO SHURIN, 2001 Wyandotte Street, Kansas City, Missouri 64108.

The summary of your claim must include the following information: (1) the name, address and telephone number of the claimant; (2) the amount of the claim; (3) the date the event on which the claim is based occurred; and (4) a brief description of the nature of the debt or the basis for the claim.

All claims against **HEARLTLAND CANCER CENTER INC** will be barred unless the proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

NOTICE OF WINDING UP
TO ALL CREDITORS OF AND CLAIMANTS AGAINST
NANCE'S URBAN LC

On October 16, 2019, NANCE'S URBAN LC, a Missouri limited liability company, filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. NANCE'S URBAN LC requests that all persons and organizations who have claims against it present them immediately by letter to NANCE'S URBAN LC, c/o CARLSON & ASSOCIATES LC, 1901 W. 47th Place, Suite 200, Westwood, KS 66205.

All claims must include the following information: (a) name and address of the claimant, (b) the amount claimed, (c) date on which the claim arose, (d) basis for the claim and documentation thereof, and (e) whether or not the claim was secured and, if so, the collateral used as security.

All claims against NANCE'S URBAN LC will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the date of publication of this notice.

NOTICE OF WINDING UP
TO ALL CREDITORS OF AND CLAIMANTS AGAINST
HUNDRED ACRE WOODS LLC

On October 16, 2019, HUNDRED ACRE WOODS LLC, a Missouri limited liability company, filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. HUNDRED ACRE WOODS LLC requests that all persons and organizations who have claims against it present them immediately by letter to HUNDRED ACRE WOODS LLC, c/o CARLSON & ASSOCIATES LC, 1901 W. 47th Place, Suite 200, Westwood, KS 66205.

All claims must include the following information: (a) name and address of the claimant, (b) the amount claimed, (c) date on which the claim arose, (d) basis for the claim and documentation thereof, and (e) whether or not the claim was secured and, if so, the collateral used as security.

All claims against HUNDRED ACRE WOODS LLC will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the date of publication of this notice.

Notice of Dissolution

to all Creditors and Claimants Against

Williamsburg Apartments, Inc.

On October 28, 2019, Williamsburg Apartments, Inc., a Missouri corporation (hereinafter the "Corporation"), filed its Dissolution by Voluntary Action with the Missouri Secretary of State.

All claims against the Corporation should be submitted in writing to: Bush & Patchett, L.L.C., Attn: Adam Patchett, 4240 Philips Farm Road, Suite 109, Columbia, Missouri, 65201. Each claim must include the following information: (1) the name, address and phone number of the claimant; (2) amount of claim; (3) date on which the claim arose; (4) basis for the claim; and (5) documentation in support of the claim.

All claims against the Corporation will be barred unless the proceeding to enforce the claim is commenced within two (2) years after the publication of this notice.

NOTICE OF WINDING UP OF LIMITED PARTNERSHIP
TO ALL CREDITORS OF AND ALL CLAIMANTS AGAINST
ONT, LP F/K/A 812 LIMITED PARTNERSHIP

Pursuant to Section 359.481.2 of the Revised Statutes of Missouri, ONT, LP, formerly "812 Limited Partnership", Missouri Charter Number: LP0867304, hereby provides notice of its intention to wind up the business and affairs of the partnership.

Persons with claims against ONT, LP, should present them in accordance with the following procedure:

(a) In order to file a claim with ONT, LP, you must furnish the following:
  (i) Amount of the claim;
  (ii) Basis for the claim; and
  (iii) Documentation supporting the claim.

(b) The claim must be mailed to:
Sherry A. Snyder
Legacy Legal Group, LLC
16401 Swingley Ridge Rd., Ste. 330
Chesterfield, MO 63017.

A claim against ONT, LP will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

Notice of Dissolution
To All Claimants Against
BROWN & GERMANN REALTY, LLC

On October 8, 2019, BROWN & GERMANN REALTY, LLC, a Missouri limited liability company (the "Company"), filed its Notice of Winding Up with the Missouri Secretary of State.

The Company requests that all persons and organizations who have claims against it present them immediately by letter to the Company at:

Spencer Fane LLP
Aaron L. Pawlitz
1 N. Brentwood Blvd., Suite 1000
St. Louis, MO 63105

All claims must include the name and address of the claimant; the amount claimed; the basis for the claim; and the date(s) on which the event(s) on which the claim is based occurred.

NOTICE: Because of the dissolution of the Company, any claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication date of this notice.

NOTICE OF WINDING UP AND DISSOLUTION
TO ALL CREDITORS AND CLAIMANTS AGAINST
SAK CONSTRUCTION OF CALIFORNIA, INC.

SAK CONSTRUCTION OF CALIFORNIA, INC., a Missouri corporation, plans to dissolve and has filed Articles of Dissolution with the Missouri Secretary of State on October 29, 2019. Any and all claims against SAK CONSTRUCTION OF CALIFORNIA, INC. should be forwarded to Roger Archibald, 864 Hoff Road, O'Fallon, Missouri 63366. Each claim should include the following: (i) the name, address and telephone number of the claimant; (ii) the amount of the claim; (iii) the basis for the claim; and (iv) documentation of the claim. Any claims against SAK CONSTRUCTION OF CALIFORNIA, INC. will be barred unless a proceeding to enforce the claim is commenced within two years after the publication of this notice.

NOTICE OF WINDING UP AND DISSOLUTION TO ALL CREDITORS AND CLAIMANTS AGAINST SAK CONSTRUCTION OF CA, L.P.

SAK CONSTRUCTION OF CA, L.P., a Missouri corporation, plans to dissolve. Any and all claims against SAK CONSTRUCTION OF CA, L.P. should be forwarded to Roger Archibald, 864 Hoff Road, O'Fallon, Missouri 63366. Each claim should include the following: (i) the name, address and telephone number of the claimant; (ii) the amount of the claim; (iii) the basis for the claim; and (iv) documentation of the claim. Any claims against SAK CONSTRUCTION OF CA, L.P. will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—43 (2018) and 44 (2019). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				44 MoReg 2847
1 CSR 10-5.010	Commissioner of Administration		43 MoReg 3208	44 MoReg 1184	
1 CSR 20-6.010	Personnel Advisory Board and Division of Personnel		44 MoReg 2665		
1 CSR 50-2.040	Missouri Ethics Commission		44 MoReg 2361		
1 CSR 50-2.070	Missouri Ethics Commission		44 MoReg 2362		
1 CSR 50-5.010	Missouri Ethics Commission	44 MoReg 2359	44 MoReg 2362		
1 CSR 50-5.020	Missouri Ethics Commission	44 MoReg 2359	44 MoReg 2362		
	DEPARTMENT OF AGRICULTURE				
2 CSR 30-2.020	Animal Health		44 MoReg 2087		
2 CSR 30-10.010	Animal Health	44 MoReg 2275	44 MoReg 2283		
2 CSR 70-10.025	Plant Industries		This Issue		
2 CSR 70-10.050	Plant Industries		This Issue		
2 CSR 70-10.075	Plant Industries		This Issue		
2 CSR 70-17.010	Plant Industries		44 MoReg 2668		
2 CSR 70-17.020	Plant Industries		44 MoReg 2670		
2 CSR 70-17.030	Plant Industries		44 MoReg 2671		
2 CSR 70-17.040	Plant Industries		44 MoReg 2672R		
2 CSR 70-17.050	Plant Industries		44 MoReg 2672		
2 CSR 70-17.060	Plant Industries		44 MoReg 2673R		
2 CSR 70-17.070	Plant Industries		44 MoReg 2673		
2 CSR 70-17.080	Plant Industries		44 MoReg 2676		
2 CSR 70-17.090	Plant Industries		44 MoReg 2676R		
2 CSR 70-17.100	Plant Industries		44 MoReg 2676		
2 CSR 70-17.110	Plant Industries		44 MoReg 2677		
2 CSR 70-17.120	Plant Industries		44 MoReg 2679		
2 CSR 70-17.130	Plant Industries		44 MoReg 2679		
2 CSR 70-35.050	Plant Industries		This Issue		
2 CSR 70-40.005	Plant Industries		44 MoReg 2363R		
2 CSR 70-40.015	Plant Industries		44 MoReg 2363R		
2 CSR 70-40.016	Plant Industries		44 MoReg 2364R		
2 CSR 70-40.017	Plant Industries		44 MoReg 2364R		
2 CSR 70-40.025	Plant Industries		44 MoReg 2364R		
2 CSR 70-40.040	Plant Industries		44 MoReg 2364R		
2 CSR 70-40.050	Plant Industries		44 MoReg 2365R		
2 CSR 70-40.055	Plant Industries		44 MoReg 2365R		
2 CSR 90	Weights, Measures and Consumer Protection				44 MoReg 2148
2 CSR 90-10.001	Weights, Measures and Consumer Protection		44 MoReg 2240	This Issue	
2 CSR 90-10.019	Weights, Measures and Consumer Protection		44 MoReg 2240	This Issue	
2 CSR 90-38.010	Weights, Measures and Consumer Protection		43 MoReg 2012R		
2 CSR 90-38.020	Weights, Measures and Consumer Protection		43 MoReg 2012R		
2 CSR 90-38.030	Weights, Measures and Consumer Protection		43 MoReg 2012R		
2 CSR 90-38.040	Weights, Measures and Consumer Protection		43 MoReg 2013R		
2 CSR 90-38.050	Weights, Measures and Consumer Protection		43 MoReg 2013R		
	DEPARTMENT OF CONSERVATION				
3 CSR 10-4.111	Conservation Commission		44 MoReg 2439		
3 CSR 10-4.117	Conservation Commission		44 MoReg 2439		
3 CSR 10-4.130	Conservation Commission		44 MoReg 2440		
3 CSR 10-4.135	Conservation Commission		44 MoReg 1832		
3 CSR 10-4.136	Conservation Commission		44 MoReg 2087	44 MoReg 2833	
3 CSR 10-4.137	Conservation Commission		44 MoReg 2088	44 MoReg 2833	
3 CSR 10-4.140	Conservation Commission		44 MoReg 2088	44 MoReg 2833	
3 CSR 10-4.145	Conservation Commission		44 MoReg 2088	44 MoReg 2833	
3 CSR 10-4.200	Conservation Commission		44 MoReg 1833		
3 CSR 10-5.205	Conservation Commission		44 MoReg 2089	44 MoReg 2834	
3 CSR 10-5.215	Conservation Commission		44 MoReg 2090	44 MoReg 2834	
3 CSR 10-5.225	Conservation Commission		44 MoReg 2091	44 MoReg 2834	
3 CSR 10-5.250	Conservation Commission		44 MoReg 1833		
3 CSR 10-5.300	Conservation Commission		44 MoReg 2091	44 MoReg 2834	
3 CSR 10-5.310	Conservation Commission		44 MoReg 2091	44 MoReg 2834	
3 CSR 10-5.320	Conservation Commission		44 MoReg 2092	44 MoReg 2834	
3 CSR 10-5.330	Conservation Commission		44 MoReg 2092	44 MoReg 2835	
3 CSR 10-5.331	Conservation Commission		44 MoReg 2092	44 MoReg 2835	
3 CSR 10-5.345	Conservation Commission		44 MoReg 2092	44 MoReg 2835	
3 CSR 10-5.430	Conservation Commission		44 MoReg 1835		
3 CSR 10-5.440	Conservation Commission		44 MoReg 1837		
3 CSR 10-5.445	Conservation Commission		44 MoReg 1839		
3 CSR 10-5.540	Conservation Commission		44 MoReg 1841		
3 CSR 10-5.545	Conservation Commission		44 MoReg 1843		
3 CSR 10-5.551	Conservation Commission		44 MoReg 1845		
3 CSR 10-5.552	Conservation Commission		44 MoReg 1847		
3 CSR 10-5.559	Conservation Commission		44 MoReg 1847		
3 CSR 10-5.560	Conservation Commission		44 MoReg 1849		
3 CSR 10-5.565	Conservation Commission		44 MoReg 1851		
3 CSR 10-5.567	Conservation Commission		44 MoReg 1853		
3 CSR 10-5.570	Conservation Commission		44 MoReg 1855		
3 CSR 10-5.576	Conservation Commission		44 MoReg 1857		
3 CSR 10-5.579	Conservation Commission		44 MoReg 1859		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
3 CSR 10-5.580	Conservation Commission		44 MoReg 1861		
3 CSR 10-5.700	Conservation Commission		44 MoReg 2093	44 MoReg 2835	
3 CSR 10-5.705	Conservation Commission		44 MoReg 2096	44 MoReg 2835	
3 CSR 10-6.550	Conservation Commission		N.A.	44 MoReg 2499	
3 CSR 10-7.405	Conservation Commission		44 MoReg 2442		
3 CSR 10-7.410	Conservation Commission		44 MoReg 2443		
3 CSR 10-7.434	Conservation Commission		N.A.	44 MoReg 2718	
3 CSR 10-7.439	Conservation Commission		44 MoReg 2445		
3 CSR 10-7.450	Conservation Commission		44 MoReg 2099	44 MoReg 2836	
3 CSR 10-7.455	Conservation Commission		44 MoReg 1998	44 MoReg 2719	44 MoReg 445
3 CSR 10-7.700	Conservation Commission		44 MoReg 2099	44 MoReg 2836	
3 CSR 10-7.705	Conservation Commission		44 MoReg 2103	44 MoReg 2837	
3 CSR 10-7.710	Conservation Commission		44 MoReg 2103	44 MoReg 2837	
3 CSR 10-7.715	Conservation Commission		44 MoReg 2104	44 MoReg 2837	
3 CSR 10-8.510	Conservation Commission		44 MoReg 2447		
3 CSR 10-9.625	Conservation Commission		44 MoReg 2104	44 MoReg 2837	
3 CSR 10-10.743	Conservation Commission		44 MoReg 2447		
3 CSR 10-10.744	Conservation Commission		44 MoReg 1863		
3 CSR 10-10.767	Conservation Commission		44 MoReg 1865		
3 CSR 10-10.768	Conservation Commission		44 MoReg 2104	44 MoReg 2837	
3 CSR 10-11.140	Conservation Commission		44 MoReg 2447		
3 CSR 10-11.145	Conservation Commission		44 MoReg 2105	44 MoReg 2838	
3 CSR 10-11.180	Conservation Commission		44 MoReg 2448		
3 CSR 10-11.186	Conservation Commission		44 MoReg 2449		
3 CSR 10-11.190	Conservation Commission		44 MoReg 2105	44 MoReg 2838	
3 CSR 10-11.200	Conservation Commission		44 MoReg 2449		
3 CSR 10-11.205	Conservation Commission		44 MoReg 2450		
3 CSR 10-20.805	Conservation Commission		44 MoReg 1867		
	DEPARTMENT OF ECONOMIC DEVELOPMENT				
4 CSR 85-5.010	Division of Business and Community Services	44 MoReg 1229 44 MoReg 2661 T	44 MoReg 1248	44 MoReg 2499	
4 CSR 85-5.020	Division of Business and Community Services	44 MoReg 1230 44 MoReg 1661 T	44 MoReg 1249	44 MoReg 2500	
4 CSR 85-5.030	Division of Business and Community Services	44 MoReg 1232	44 MoReg 1251	44 MoReg 2501	
4 CSR 85-5.040	Division of Business and Community Services	44 MoReg 1233	44 MoReg 1252	44 MoReg 2501	
4 CSR 85-5.050	Division of Business and Community Services	44 MoReg 1233	44 MoReg 1252	44 MoReg 2501	
4 CSR 85-5.060	Division of Business and Community Services	44 MoReg 1234	44 MoReg 1253	44 MoReg 2502	
4 CSR 85-5.070	Division of Business and Community Services	44 MoReg 1234	44 MoReg 1253	44 MoReg 2502	
4 CSR 85-5.080	Division of Business and Community Services	44 MoReg 1235	44 MoReg 1253	44 MoReg 2502	
4 CSR 85-5.090	Division of Business and Community Services	44 MoReg 1235	44 MoReg 1254	44 MoReg 2503	
4 CSR 85-5.100	Division of Business and Community Services	44 MoReg 1236	44 MoReg 1254	44 MoReg 2503	
4 CSR 85-5.110	Division of Business and Community Services	44 MoReg 1237	44 MoReg 1255	44 MoReg 2503	
4 CSR 340-2	Division of Energy				44 MoReg 1758
	DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION				
5 CSR 20-100.190	Division of Learning Services		43 MoReg 3780	44 MoReg 1392	
5 CSR 20-100.295	Division of Learning Services		44 MoReg 2105		
5 CSR 20-100.320	Division of Learning Services	44 MoReg 2433	44 MoReg 2450		
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5 CSR 20-600.110	Division of Learning Services *(Changed to 5 CSR 20-100.330)*		44 MoReg 79	44 MoReg 1333	
5 CSR 20-600.120	Division of Learning Services *(Changed to 5 CSR 20-100.300)*				43 MoReg 3651
5 CSR 20-600.130	Division of Learning Services *(Changed to 5 CSR 20-100.310)*				43 MoReg 3651
5 CSR 20-600.140	Division of Learning Services *(Changed to 5 CSR 20-100.320)*				43 MoReg 3651
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5 CSR 100-200.095	Missouri Commission for the Deaf and Hard of Hearing		44 MoReg 2116	44 MoReg 2839	
5 CSR 100-200.125	Missouri Commission for the Deaf and Hard of Hearing		44 MoReg 2116	44 MoReg 2839	
5 CSR 100-200.130	Missouri Commission for the Deaf and Hard of Hearing		44 MoReg 2117	44 MoReg 2839	
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9 CSR 30-4.010	Certification Standards		44 MoReg 1505R	44 MoReg 2609R	
9 CSR 30-4.020	Certification Standards		44 MoReg 1505R	44 MoReg 2609R	
9 CSR 30-4.030	Certification Standards		44 MoReg 1505R	44 MoReg 2609R	
9 CSR 30-4.031	Certification Standards		44 MoReg 1506R	44 MoReg 2609R	
9 CSR 30-4.032	Certification Standards		44 MoReg 1506	44 MoReg 2609	
9 CSR 30-4.033	Certification Standards		44 MoReg 1507R	44 MoReg 2610R	
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9 CSR 30-4.160	Certification Standards		44 MoReg 1539R	44 MoReg 2617R	
9 CSR 30-4.190	Certification Standards		44 MoReg 1539	44 MoReg 2618	
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10 CSR 10-5.570	Air Conservation Commission		44 MoReg 2009		
10 CSR 10-6.030	Air Conservation Commission		44 MoReg 1138	44 MoReg 2503	
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10 CSR 10-6.200	Air Conservation Commission		44 MoReg 1872		
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13 CSR 70-15.010	MO HealthNet Division	44 MoReg 2235			
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20 CSR 400-7	Life, Annuities and Health				44 MoReg 2625
20 CSR 400-11	Life, Annuities and Health				44 MoReg 2626
20 CSR 400-12	Life, Annuities and Health				44 MoReg 2626
20 CSR 400-13	Life, Annuities and Health				44 MoReg 2626
20 CSR 400-14.100	Life, Annuities and Health		44 MoReg 1724	44 MoReg 2534	
20 CSR 500-1	Property and Casualty				44 MoReg 2626
20 CSR 500-2	Property and Casualty				44 MoReg 2627
20 CSR 500-4	Property and Casualty				44 MoReg 2627
20 CSR 500-5	Property and Casualty				44 MoReg 2627
20 CSR 500-6	Property and Casualty				44 MoReg 2627
20 CSR 500-7	Property and Casualty				44 MoReg 2627
20 CSR 500-8	Property and Casualty				44 MoReg 2628
20 CSR 500-9	Property and Casualty				44 MoReg 2628
20 CSR 600-1	Statistical Reporting				44 MoReg 2628
20 CSR 600-1.010	Statistical Reporting		44 MoReg 1724	44 MoReg 2534	
20 CSR 600-3	Statistical Reporting				44 MoReg 2628
20 CSR 600-3.100	Statistical Reporting		44 MoReg 1725	44 MoReg 2534	
20 CSR 700-1	Insurance Licensing				44 MoReg 2628
20 CSR 700-1.170	Insurance Licensing		44 MoReg 1725	44 MoReg 2534	
20 CSR 700-3	Insurance Licensing				44 MoReg 2628
20 CSR 700-6	Insurance Licensing				44 MoReg 2629
20 CSR 700-8	Insurance Licensing				44 MoReg 2629
20 CSR 800-1	Administrative Procedures Under the Insurance Laws				44 MoReg 2629
20 CSR 800-3	Administrative Procedures Under the Insurance Laws				44 MoReg 2629
20 CSR 2010-4.010	Missouri State Board of Accountancy		44 MoReg 1936	44 MoReg 2845	
20 CSR 2010-4.020	Missouri State Board of Accountancy		44 MoReg 1936	44 MoReg 2846	
20 CSR 2010-4.031	Missouri State Board of Accountancy		44 MoReg 1937	44 MoReg 2846	
20 CSR 2010-4.035	Missouri State Board of Accountancy		44 MoReg 1937	44 MoReg 2846	
20 CSR 2010-4.041	Missouri State Board of Accountancy		44 MoReg 1938	44 MoReg 2846	
20 CSR 2010-5.070	Missouri State Board of Accountancy		44 MoReg 2385		
20 CSR 2010-5.080	Missouri State Board of Accountancy		44 MoReg 2385		
20 CSR 2010-5.090	Missouri State Board of Accountancy		44 MoReg 2386		
20 CSR 2010-5.100	Missouri State Board of Accountancy		44 MoReg 2387		
20 CSR 2010-5.110	Missouri State Board of Accountancy		44 MoReg 2387		
20 CSR 2015	Acupuncturist Advisory Committee				44 MoReg 2539
20 CSR 2030	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				44 MoReg 2539
20 CSR 2030-4.090	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		44 MoReg 1558	44 MoReg 2534	
20 CSR 2030-5.080	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		44 MoReg 2301		
20 CSR 2030-5.105	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		44 MoReg 1558	44 MoReg 2535	
20 CSR 2030-5.110	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		44 MoReg 2301		
20 CSR 2030-5.150	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		44 MoReg 1559	44 MoReg 2535	
20 CSR 2030-10.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		44 MoReg 1559	44 MoReg 2535	
20 CSR 2040	Office of Athletics				44 MoReg 2539
20 CSR 2040-4.015	Office of Athletics		This Issue		
20 CSR 2045	Athlete Agents				44 MoReg 2539
20 CSR 2065	Endowed Care Cemeteries				44 MoReg 2540
20 CSR 2070	State Board of Chiropractic Examiners				44 MoReg 2725
20 CSR 2095	Committee for Professional Counselors				44 MoReg 2540
20 CSR 2115	State Committee of Dietitians				44 MoReg 2540
20 CSR 2117	Office of Statewide Electrical Contractors				44 MoReg 2540
20 CSR 2120-1.010	State Board of Embalmers and Funeral Directors		44 MoReg 2014	27 MoReg 2722	

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20 CSR 2120-2.080	State Board of Embalmers and Funeral Directors		44 MoReg 2015	27 MoReg 2722	
20 CSR 2120-2.090	State Board of Embalmers and Funeral Directors		44 MoReg 2015	44 MoReg 2722	
20 CSR 2120-2.120	State Board of Embalmers and Funeral Directors		44 MoReg 2016	44 MoReg 2723	
20 CSR 2120-2.130	State Board of Embalmers and Funeral Directors		44 MoReg 2017	44 MoReg 2723	
20 CSR 2120-3.030	State Board of Embalmers and Funeral Directors		44 MoReg 2017	44 MoReg 2723	
20 CSR 2145	Missouri Board of Geologist Registration				44 MoReg 2725
20 CSR 2145-2.020	Missouri Board of Geologist Registration		44 MoReg 2302		
20 CSR 2145-2.040	Missouri Board of Geologist Registration		44 MoReg 2302		
20 CSR 2145-2.100	Missouri Board of Geologist Registration		44 MoReg 2303		
20 CSR 2165-1.030	Board of Examiners for Hearing Instrument Specialists		44 MoReg 2710		
20 CSR 2165-2.020	Board of Examiners for Hearing Instrument Specialists		44 MoReg 2710		
20 CSR 2165-2.030	Board of Examiners for Hearing Instrument Specialists		44 MoReg 2711		
20 CSR 2165-2.035	Board of Examiners for Hearing Instrument Specialists		44 MoReg 2712		
20 CSR 2165-2.065	Board of Examiners for Hearing Instrument Specialists		44 MoReg 2715		
20 CSR 2165-2.070	Board of Examiners for Hearing Instrument Specialists		44 MoReg 2715		
20 CSR 2165-3.010	Board of Examiners for Hearing Instrument Specialists		44 MoReg 2716		
20 CSR 2165-3.020	Board of Examiners for Hearing Instrument Specialists		44 MoReg 2716		
20 CSR 2165-3.030	Board of Examiners for Hearing Instrument Specialists		44 MoReg 2717		
20 CSR 2193	Interior Design Council				44 MoReg 2725
20 CSR 2197-1.010	Board of Therapeutic Massage		44 MoReg 2473R		
20 CSR 2197-1.020	Board of Therapeutic Massage		44 MoReg 2473R		
20 CSR 2197-1.030	Board of Therapeutic Massage		44 MoReg 2473R		
20 CSR 2197-2.010	Board of Therapeutic Massage		44 MoReg 2474		
20 CSR 2197-2.020	Board of Therapeutic Massage		44 MoReg 2480R		
20 CSR 2197-2.030	Board of Therapeutic Massage		44 MoReg 2480		
20 CSR 2197-2.040	Board of Therapeutic Massage		44 MoReg 2481		
20 CSR 2197-2.050	Board of Therapeutic Massage		44 MoReg 2481		
20 CSR 2197-3.005	Board of Therapeutic Massage		44 MoReg 2482R		
20 CSR 2197-3.010	Board of Therapeutic Massage		44 MoReg 2482		
20 CSR 2197-4.030	Board of Therapeutic Massage		44 MoReg 2484		
20 CSR 2197-4.040	Board of Therapeutic Massage		44 MoReg 2487R		
20 CSR 2197-5.010	Board of Therapeutic Massage		44 MoReg 2487R 44 MoReg 2487		
20 CSR 2197-5.020	Board of Therapeutic Massage		44 MoReg 2488		
20 CSR 2197-5.030	Board of Therapeutic Massage		44 MoReg 2492R		
20 CSR 2197-5.040	Board of Therapeutic Massage		44 MoReg 2492R		
20 CSR 2197-6.010	Board of Therapeutic Massage		44 MoReg 2492		
20 CSR 2197-6.020	Board of Therapeutic Massage		44 MoReg 2493R		
20 CSR 2200	State Board of Nursing				44 MoReg 2540
20 CSR 2200-4.020	State Board of Nursing		44 MoReg 2127	44 MoReg 2846	
20 CSR 2205	Missouri Board of Occupational Therapy				44 MoReg 2725
20 CSR 2205-5.010	Missouri Board of Occupational Therapy		44 MoReg 2388		
20 CSR 2220-2.016	State Board of Pharmacy		44 MoReg 1726	44 MoReg 2535	
20 CSR 2220-2.050	State Board of Pharmacy		44 MoReg 1727	44 MoReg 2535	
20 CSR 2220-2.060	State Board of Pharmacy		44 MoReg 1728	44 MoReg 2535	
20 CSR 2220-2.080	State Board of Pharmacy		44 MoReg 1728	44 MoReg 2536	
20 CSR 2220-2.120	State Board of Pharmacy		44 MoReg 1388	44 MoReg 2536	
20 CSR 2220-2.150	State Board of Pharmacy		44 MoReg 1729	44 MoReg 2536	
20 CSR 2220-2.180	State Board of Pharmacy		44 MoReg 1729	44 MoReg 2723	
20 CSR 2220-2.300	State Board of Pharmacy		44 MoReg 1730	44 MoReg 2536	
20 CSR 2220-2.500	State Board of Pharmacy		44 MoReg 1560	44 MoReg 2537	
20 CSR 2220-2.600	State Board of Pharmacy		44 MoReg 1730	44 MoReg 2537	
20 CSR 2220-2.800	State Board of Pharmacy		44 MoReg 1732	44 MoReg 2537	
20 CSR 2220-2.990	State Board of Pharmacy	44 MoReg 2275	44 MoReg 2304		
20 CSR 2220-2.995	State Board of Pharmacy	44 MoReg 2573	44 MoReg 2580		
20 CSR 2220-3.011	State Board of Pharmacy		44 MoReg 1389	44 MoReg 2537	
20 CSR 2220-4.010	State Board of Pharmacy	44 MoReg 2238			
20 CSR 2220-6.030	State Board of Pharmacy		44 MoReg 1732R	44 MoReg 2538R	
20 CSR 2220-7.080	State Board of Pharmacy		44 MoReg 1732	44 MoReg 2538	
20 CSR 2230-1.010	State Board of Podiatric Medicine		44 MoReg 1735	44 MoReg 2538	
20 CSR 2230-2.010	State Board of Podiatric Medicine		44 MoReg 2821		
20 CSR 2230-2.015	State Board of Podiatric Medicine		44 MoReg 2822		
20 CSR 2230-2.023	State Board of Podiatric Medicine		44 MoReg 2391		
20 CSR 2230-2.030	State Board of Podiatric Medicine		44 MoReg 2392		
20 CSR 2230-2.032	State Board of Podiatric Medicine		44 MoReg 2823		
20 CSR 2230-2.035	State Board of Podiatric Medicine		44 MoReg 2823		
20 CSR 2230-2.036	State Board of Podiatric Medicine		44 MoReg 2824		
20 CSR 2230-2.050	State Board of Podiatric Medicine		44 MoReg 2825		
20 CSR 2230-2.055	State Board of Podiatric Medicine		44 MoReg 2826		
20 CSR 2230-2.065	State Board of Podiatric Medicine		44 MoReg 2829		
20 CSR 2230-2.070	State Board of Podiatric Medicine		44 MoReg 2830		
20 CSR 2232	Missouri State Committee of Interpreters				44 MoReg 2726
20 CSR 2232-3.030	Missouri State Committee of Interpreters		44 MoReg 2307		
20 CSR 2233-1.010	State Committee of Marital and Family Therapists		44 MoReg 2582		
20 CSR 2233-1.020	State Committee of Marital and Family Therapists		44 MoReg 2582		
20 CSR 2233-1.030	State Committee of Marital and Family Therapists		44 MoReg 2582		
20 CSR 2233-1.040	State Committee of Marital and Family Therapists		44 MoReg 1565 This Issue	44 MoReg 2538	
20 CSR 2233-1.050	State Committee of Marital and Family Therapists		44 MoReg 2583		
20 CSR 2233-2.010	State Committee of Marital and Family Therapists		44 MoReg 2583		
20 CSR 2233-2.020	State Committee of Marital and Family Therapists		44 MoReg 2586		

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20 CSR 2233-2.021	State Committee of Marital and Family Therapists		44 MoReg 2588		
20 CSR 2233-2.030	State Committee of Marital and Family Therapists		44 MoReg 2589		
20 CSR 2233-2.040	State Committee of Marital and Family Therapists		44 MoReg 2589		
20 CSR 2233-2.050	State Committee of Marital and Family Therapists		44 MoReg 2590		
20 CSR 2233-3.010	State Committee of Marital and Family Therapists		44 MoReg 2591		
20 CSR 2234	Board of Private Investigator and Private Fire Examiners				44 MoReg 2540
20 CSR 2245	Real Estate Appraisers				44 MoReg 2726
20 CSR 2245-1.010	Real Estate Appraisers		44 MoReg 2018	44 MoReg 2724	
20 CSR 2245-3.005	Real Estate Appraisers		44 MoReg 2018	44 MoReg 2724	
20 CSR 2245-3.010	Real Estate Appraisers		44 MoReg 2019	44 MoReg 2724	
20 CSR 2245-6.040	Real Estate Appraisers		44 MoReg 2019	44 MoReg 2724	
20 CSR 2245-8.010	Real Estate Appraisers		44 MoReg 2020	44 MoReg 2724	
20 CSR 2245-8.030	Real Estate Appraisers		44 MoReg 2020	44 MoReg 2724	
20 CSR 2255	Missouri Board for Respiratory Care				44 MoReg 2540
20 CSR 2263	State Committee for Social Workers				44 MoReg 2726
20 CSR 2263-2.032	State Committee for Social Workers		44 MoReg 2493		
20 CSR 2263-2.082	State Committee for Social Workers		44 MoReg 2493		
20 CSR 2263-3.010	State Committee for Social Workers		44 MoReg 2494		
20 CSR 2263-3.020	State Committee for Social Workers		44 MoReg 2494		
20 CSR 2263-3.040	State Committee for Social Workers		44 MoReg 2495		
20 CSR 2263-3.060	State Committee for Social Workers		44 MoReg 2496		
20 CSR 2263-3.080	State Committee for Social Workers		44 MoReg 2496		
20 CSR 2263-3.100	State Committee for Social Workers		44 MoReg 2497		
20 CSR 2263-3.120	State Committee for Social Workers		44 MoReg 2497		
20 CSR 2263-3.140	State Committee for Social Workers		44 MoReg 2498		
20 CSR 2267	Office of Tattooing, Body Piercing, and Branding				44 MoReg 2726
20 CSR 2267-1.010	Office of Tattooing, Body Piercing, and Branding		44 MoReg 2592		
20 CSR 2267-1.020	Office of Tattooing, Body Piercing, and Branding		44 MoReg 2593		
20 CSR 2267-1.030	Office of Tattooing, Body Piercing, and Branding		44 MoReg 2593		
20 CSR 2267-2.010	Office of Tattooing, Body Piercing, and Branding		44 MoReg 2594		
20 CSR 2267-2.020	Office of Tattooing, Body Piercing, and Branding		44 MoReg 2597		
20 CSR 2267-2.030	Office of Tattooing, Body Piercing, and Branding		44 MoReg 2600		
20 CSR 2267-2.034	Office of Tattooing, Body Piercing, and Branding		44 MoReg 2602		
20 CSR 2267-3.010	Office of Tattooing, Body Piercing, and Branding		44 MoReg 2605		
20 CSR 2267-4.010	Office of Tattooing, Body Piercing, and Branding		44 MoReg 2605		
20 CSR 2267-5.010	Office of Tattooing, Body Piercing, and Branding		44 MoReg 2606		
20 CSR 2267-5.040	Office of Tattooing, Body Piercing, and Branding		44 MoReg 2606		
20 CSR 2270-4.050	Missouri Veterinary Medical Board		44 MoReg 2394		
20 CSR 2270-5.011	Missouri Veterinary Medical Board		44 MoReg 2396		
	MISSOURI CONSOLIDATED HEALTH CARE PLAN				
22 CSR 10-2.020	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.045	Health Care Plan	This IssueR	This IssueR		
22 CSR 10-2.045	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.046	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.047	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.053	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.055	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.061	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.070	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.075	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.089	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.090	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.110	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.020	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.045	Health Care Plan	This IssueR	This IssueR		
22 CSR 10-3.045	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.055	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.057	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.058	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.059	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.061	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.070	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.075	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.090	Health Care Plan	This Issue	This Issue		

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Office of Administration				
Missouri Ethics Commission				
1 CSR 50-5.010	Definitions	44 MoReg 2359	Aug. 18, 2019	Feb. 27, 2020
1 CSR 50-5.020	Registration Requirements for Committees Domiciled Outside the State of Missouri and Out-of-State Committees	44 MoReg 2359	Aug. 18, 2019	Feb. 27, 2020
Department of Agriculture				
Animal Health				
2 CSR 30-10.010	Inspection of Meat and Poultry	44 MoReg 2275	July 28, 2019	Feb. 27, 2020
Department of Economic Development				
Division of Business and Community Services				
4 CSR 85-5.010	Overview and Definitions	44 MoReg 1229	March 30, 2019	Term. Nov. 29, 2019
4 CSR 85-5.020	Applications	44 MoReg 1230	March 30, 2019	Term. Nov. 29, 2019
4 CSR 85-5.030	Preliminary Application Evaluation- Net Fiscal Benefit	44 MoReg 1232	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.040	Preliminary Application- Overall Size and Quality of the Project	44 MoReg 1233	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.050	Preliminary Application- Level of Economic Distress	44 MoReg 1233	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.060	Preliminary Application- Input from Local Elected Officials	44 MoReg 1234	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.070	Compliance with Other Provisions of Law	44 MoReg 1234	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.080	Phased Projects	44 MoReg 1235	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.090	Developer Fees; General Contractor Requirements	44 MoReg 1235	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.100	Not-for-Profits	44 MoReg 1236	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.110	Administrative Closure	44 MoReg 1237	March 30, 2019	Dec. 31, 2019
Department of Elementary and Secondary Education				
Division of Learning Services				
5 CSR 20-100.320	Prekindergarten Program Standards	44 MoReg 2433	Aug. 28, 2019	Feb. 27, 2020
Department of Revenue				
Director of Revenue				
12 CSR 10-2.015	Employers' Withholding of Tax	44 MoReg 1493	April 26, 2019	Feb. 5, 2020
12 CSR 10-41.010	Annual Adjusted Rate of Interest	This Issue	Jan. 1, 2020	June 28, 2020
Department of Social Services				
Division of Finance and Administrative Services				
13 CSR 10-4.010	Prohibition Against Expenditure of Appropriated Funds for Abortion Facilities	44 MoReg 2079	July 1, 2019	Dec. 26, 2019
MO HealthNet Division				
13 CSR 70-10.016	Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates	44 MoReg 1661	June. 1, 2019	Dec. 30, 2019
13 CSR 70-10.030	Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/IID Services	This Issue	Nov. 8, 2019	May 5, 2020
13 CSR 70-10.110	Nursing Facility Reimbursement Allowance	44 MoReg 1664	June 1, 2019	Dec. 30, 2019
13 CSR 70-15.010	Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology	44 MoReg 2235	July 12, 2019	Feb. 27, 2020
13 CSR 70-15.110	Federal Reimbursement Allowance (FRA)	44 MoReg 2236	July 12, 2019	Feb. 27, 2020
Elected Officials				
Secretary of State				
15 CSR 30-14.010	Campaign Contribution Limits	44 MoReg 1241	March 30, 2019	Jan. 8, 2020
Department of Health and Senior Services				
Office of the Director				
19 CSR 10-4.020	J-1 Visa Waiver Program (Res)	44 MoReg 2661	Oct. 1, 2019	March 27, 2020
19 CSR 10-4.020	J-1 Visa Waiver Program	44 MoReg 2662	Oct. 1, 2019	March 27, 2020
19 CSR 10-15.060	Prohibition on Expenditure of Funds	44 MoReg 2079	July 1, 2019	Feb. 27, 2020
Division of Community and Public Health				
19 CSR 20-20.020	Reporting Infectious, Contagious, Communicable, or Dangerous Diseases	44 MoReg 2081	July 8, 2019	Feb. 27, 2020
19 CSR 20-20.040	Measures to Determine the Prevalence and Prevent the Spread of Diseases which are Infectious, Contagious, Communicable, or Dangerous in their Nature	44 MoReg 2082	July 8, 2019	Feb. 27, 2020

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Division of Regulation and Licensure			
19 CSR 30-30.060 Standards for the Operation of Abortion Facilities	44 MoReg 2084	July 1, 2019	Feb. 27, 2020
19 CSR 30-40.750 ST-Segment Elevation Myocardial Infarction (STEMI) Center Resignation Application and Review	44 MoReg 2434	Sept. 12, 2019	March 9, 2020
Department of Health and Senior Services			
Division of Regulation and Licensure			
19 CSR 30-95.010 Definitions	44 MoReg 1795	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.025 Generally Applicable Provisions	44 MoReg 1797	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.030 Qualifying Patient/Primary Caregiver	44 MoReg 1804	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.040 Medical Marijuana Facilities Generally	44 MoReg 1809	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.050 Cultivation Facility	44 MoReg 1818	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.060 Infused Products Manufacturing Facility	44 MoReg 1818	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.070 Testing Facility	44 MoReg 1819	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.080 Dispensary Facility	44 MoReg 1822	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.090 Seed to Sale Tracking	44 MoReg 1823	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.100 Transportation	44 MoReg 1825	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.110 Physicians	44 MoReg 1826	June 3, 2019	Feb. 27, 2020
Department of Insurance, Financial Institutions and Professional Registration			
State Board of Pharmacy			
20 CSR 2220-2.995 Board Approved Pilot and Research Projects	44 MoReg 2573	Sept. 27, 2019	March 24, 2020
20 CSR 2220-2.400 Compounding Standards of Practice	44 MoReg 1241	March 30, 2019	Jan. 8, 2020
20 CSR 2220-2.990 Rx Cares for Missouri Program	44 MoReg 2275	July 28, 2019	Feb. 27, 2020
20 CSR 2220-4.010 General Fees	44 MoReg 2238	July 20, 2019	Nov. 5, 2019
Missouri Veterinary Medical Board			
20 CSR 2270-4.031 Minimum Standards for Practice Techniques	44 MoReg 1242	March 30, 2019	Jan. 8, 2020
Missouri Consolidated Health Care Plan			
Health Care Plan			
22 CSR 10-2.020 General Membership Provisions	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-2.045 Plan Utilization Review Policy (Res)	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-2.045 Plan Utilization Review Policy	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-2.047 PPO 1250 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-2.061 Plan Limitations	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-2.070 Coordination of Benefits	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-2.075 Review and Appeals Procedure	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-2.090 Pharmacy Benefit Summary	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-2.110 General Foster Parent Membership Provisions	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-3.020 General Membership Provisions	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-3.045 Plan Utilization Review Policy (Res)	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-3.045 Plan Utilization Review Policy	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-3.058 PPO 750 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-3.059 PPO 1250 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-3.061 Plan Limitations	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-3.070 Coordination of Benefits	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-3.075 Review and Appeals Procedure	This Issue	Jan. 1, 2020	June 28, 2020
22 CSR 10-3.090 Pharmacy Benefit Summary	This Issue	Jan. 1, 2020	June 28, 2020

Executive Orders	Subject Matter	Filed Date	Publication
	2019		
19-20	Creates the Office of Apprenticeship and Work-Based Learning (OAWBL) and makes it a distinct office within the Missouri Department of Higher Education and Workforce Development	Nov. 12, 2019	Next Issue
19-19	Closes state offices November 29, 2019	Nov. 4, 2019	44 MoReg 2816
Proclamation	Governor reduces line items in the budget	Oct. 28, 2019	This Issue
19-18	Orders the Department of Health and Senior Services, Department of Elementary and Secondary Education, and the Department of Public Safety to develop a statewide campaign to deter the use of vaping devices by Missouri youths	Oct. 15, 2019	44 MoReg 2815
19-17	Rescinds Executive Order 81-24	Sept. 20, 2019	44 MoReg 2664
19-16	Orders the commencement of the Missouri as a Model Employer Initiative, with directives for the State of Missouri employing people with disabilities	Sept. 9, 2019	44 MoReg 2576
19-15	Declares the Department of Higher Education be henceforth called Department of Higher Education and Workforce Development	Aug. 28, 2019	44 MoReg 2438
Proclamation	Calls for a Special Session of the One Hundredth General Assembly	Aug. 21, 2019	44 MoReg 2436
19-14	Establishes the Flood Recovery Advisory Working Group	July 18, 2019	44 MoReg 2281
19-13	Establishes the Missouri Health Insurance Innovation Task Force	July 17, 2019	44 MoReg 2278
19-12	Closes state offices July 5, 2019	July 3, 2019	44 MoReg 2239
19-11	Establishes the Missouri Food, Beverage, and Forest Products Manufacturing Task Force	June 28, 2019	44 MoReg 2085
19-10	Extends Executive Order 19-06 - State of Emergency	June 13, 2019	44 MoReg 1993
19-09	Calls and orders into active service, portions of the organized militia as necessary to aid executive officials in protecting life and property	May 27, 2019	44 MoReg 1830
19-08	Declares a State of Emergency	May 21, 2019	44 MoReg 1828
Writ of Election	Fills vacancy in the One Hundredth General Assembly from the 158th district	April 23, 2019	44 MoReg 1499
Writ of Election	Fills vacancy in the One Hundredth General Assembly from the 99th district	April 23, 2019	44 MoReg 1497
19-07	Extends Executive Order 19-06 - State of Emergency	April 30, 2019	44 MoReg 1501
19-06	Gives the Department of Natural Resources discretionary authority to waive or suspend operation to best serve the interests of the public health and safety during the State of Emergency	March 29, 2019	44 MoReg 1246
19-05	Declares a State of Emergency	March 21, 2019	44 MoReg 1244
19-04	Establishes the Missouri School Safety Task Force	March 13, 2019	44 MoReg 1131
Proclamation	Governor reduces line items in the budget	Jan. 28, 2019	44 MoReg 771
19-03	Transfers the Division of Workforce Development to the Department of Higher Education	Jan. 17, 2019	44 MoReg 767
19-02	Transfers the Office of Public Counsel and Public Service Commission to the Department of Insurance, Financial Institutions and Professional Registration	Jan. 17, 2019	44 MoReg 765
19-01	Transfers the Division of Energy to the Department of Natural Resources	Jan. 17, 2019	44 MoReg 763
	2018		
18-12	Establishes the Missouri 2020 Complete Count Committee	Dec. 18, 2018	44 MoReg 498
18-11	Closes state offices December 24, 2018	Nov. 30, 2018	43 MoReg 3761
18-10	Establishes that each executive branch adhere to the code of conduct regarding gifts form lobbyist	Nov. 20, 2018	44 MoReg 36
18-09	Closes state offices November 23, 2018	Nov. 1, 2018	43 MoReg 3204
18-08	Establishes the Missouri Justice Reinvestment Executive Oversight Council.	Oct. 25, 2018	43 MoReg 3472
Proclamation	Governor temporarily reduces line items in the budget	Oct. 31, 2018	43 MoReg 3416
18-07	Establishes the Bicentennial Commission	Oct. 12, 2018	43 MoReg 3202
Proclamation	Calls upon the Senators and Representatives to enact legislation requiring the Department of Elementary and Secondary Education to establish a statewide program to be known as the "STEM Career Awareness Program"	Sept. 4, 2018	43 MoReg 2780
18-06	Designates those members of the governor's staff who have supervisory authority over each department, division, or agency of state government.	Aug. 21, 2018	43 MoReg 2778
18-05	Declares a drought alert for 47 Missouri counties and orders the director of the Department of Natural Resources to activate and designate a chairperson for the Drought Assessment Committee	July 18, 2018	43 MoReg 2539
18-04	Extends the deadline from Section 3d of Executive Order 17-03 through September 30,2018	June 29, 2018	43 MoReg 1996
18-03	Reauthorizes and restructures the Homeland Security Advisory Council.	April 25, 2018	43 MoReg 1123

Executive Orders	Subject Matter	Filed Date	Publication
18-02	Declares a State of Emergency and activates the state militia in response to severe weather that began on Feb. 23	Feb. 24, 2018	43 MoReg 664
Proclamation	Governor notifies the General Assembly that he is reducing appropriation lines in the fiscal year 2018 budget	Feb. 14, 2018	43 MoReg 519
18-01	Rescinds Executive Order 07-21	Jan. 4, 2018	43 MoReg 251

The rule number and the MoReg publication date follow each entry to this index.

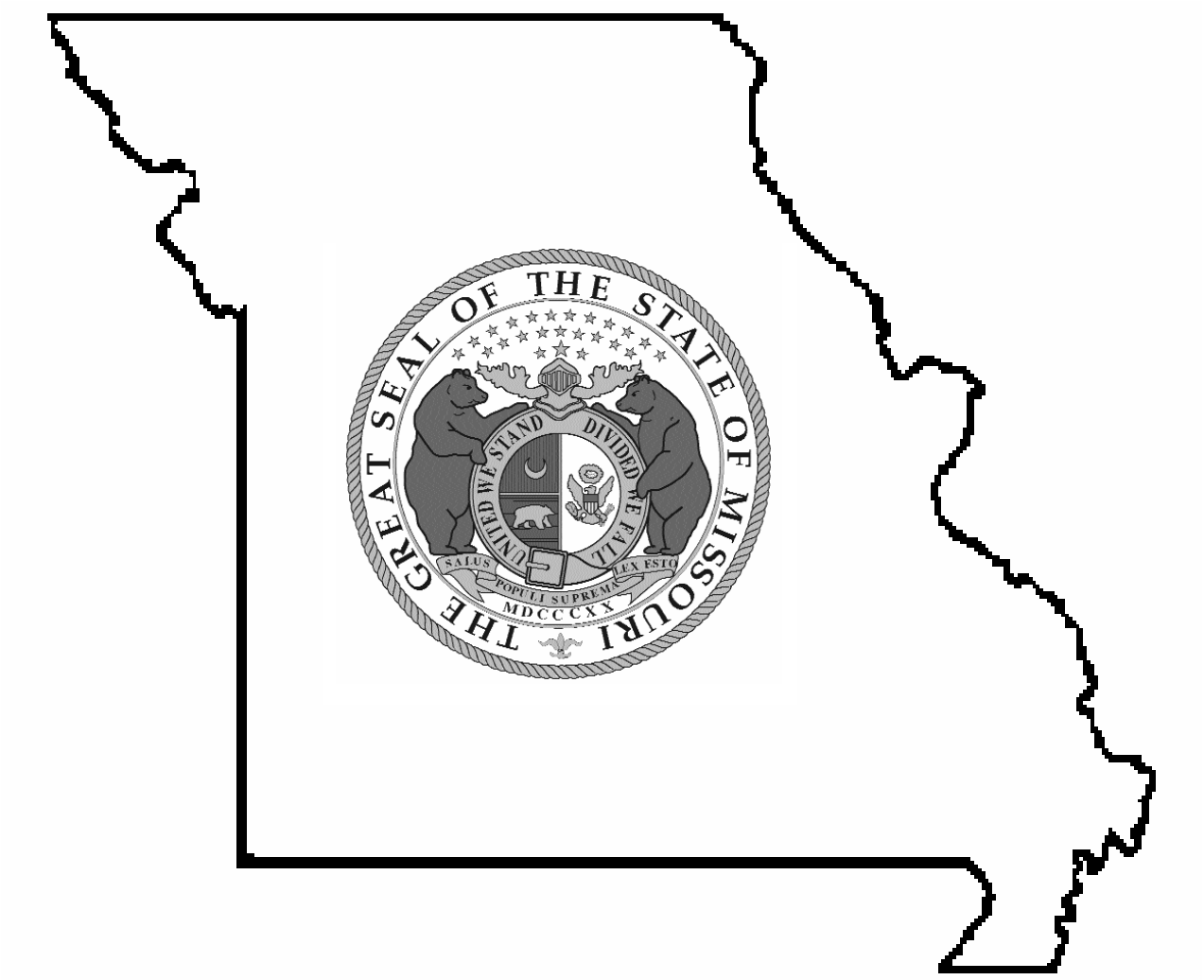
INTERPRETERS, MISSOURI STATE COMMITTEE OF

LABOR AND INDUSTRIAL RELATIONS, DEPARTMENT OF

MARITAL AND FAMILY, STATE COMMITTEE OF

MENTAL HEALTH, DEPARTMENT OF

MISSOURI STATE RULEMAKING MANUAL



JOHN R. ASHCROFT
SECRETARY OF STATE

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